



# Cigna Healthcare Value 3-Tier Prescription Drug List

Coverage as of January 1, 2026

## For the State of California

Exclusive Provider Organization (EPO), LocalPlus (LocalPlus IN/LocalPlus), Open Access Plus (OAPIN/OAP), Preferred Provider Organization (PPO), SureFit

View your drug list online: [Cigna.com/druglist](https://Cigna.com/druglist)

24/7 Customer Service: **800.Cigna24 (800.244.6224)**

View your coverage info online: myCigna® App or [myCigna.com](https://myCigna.com)®

Last updated: 12/01/2025. This drug list is subject to change and all prior versions are no longer in effect.



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### View your drug list online, 24/7

This document was last updated on 12/01/2025.\* Go online to see the most up-to-date information about the medications your plan covers.

- **Cigna.com/druglist.** Choose **Value 3 Tier** from the dropdown list. Then type in your medication name or view the full list.
- **myCigna App<sup>1</sup> or myCigna.com.** Log into your account and use the Price a Medication tool to see how your medication is covered.

### Questions?

- **By phone:** Call the toll-free number on your Cigna Healthcare® ID card. We're here 24/7/365.
- **myCigna.com:** Click to Chat - Monday-Friday, 9:00 am-8:00 pm EST.

\* Drug list created: originally created 01/01/2004

Last updated: 12/01/2025, for changes starting 01/01/2026

Next planned update: 04/01/2026, for changes starting 07/01/2026

## Information about this drug list

### Frequently asked questions (FAQs)

Here are answers to questions you may have about your drug list and prescription medication coverage.

#### **Q. How often is the drug list updated? How do I know if my medication coverage changed?**

**A.** We review and update the drug list on a regular basis to make sure you have coverage for low-cost, safe and effective medications. We make changes for many reasons; for example, when a new medication comes out or is no longer available, or when a medication's price changes. These changes may include:

- **Moving a medication to a lower cost tier.** This can happen at any time during the year.
- **Moving a brand medication to a higher cost tier when a generic comes out.** This can happen at any time during the year.
- **Moving a medication to a higher cost tier and/or no longer covering a medication.** This typically happens twice a year on January 1 and July 1.
- **Adding extra coverage rules (requirements) to a medication.** This typically happens twice a year on January 1 and July 1.

When we make a change that affects your medication (for example, it'll cost more, won't be covered, and/or has an extra coverage requirement), we let you know before it happens. This way, you have time to talk with your doctor about your options. Only you and your doctor can decide what's best for your treatment.

#### **Q. Why doesn't my plan cover certain medications?**

**A.** To help lower your overall health care costs, your plan doesn't cover certain high-cost brand-name medications that have lower-cost alternatives that can treat the same condition. If your medication isn't covered and your doctor feels a different medication isn't right for you, your doctor's office can ask us to cover it through our review process.

There are also some medications and products that your plan won't cover for any reason because they're a "plan (or benefit) exclusion." This means the medication or product isn't on your drug list, and there's no option to ask us to cover it through our review process.

For example, your plan doesn't cover (or "excludes"):

- Prescription medications that treat allergies (ex. Allegra, Clarinex, Xyzal and generics) and heartburn/stomach acid conditions (ex. Nexium, Prilosec OTC and generics).
- Medications that treat lifestyle conditions, such as infertility, erectile dysfunction and smoking cessation.<sup>2</sup>
- Medications that the U.S. Food and Drug Administration (FDA) hasn't approved.

#### **Q. How do you decide which medications to cover?**

**A.** The Cigna Healthcare Prescription Drug List is developed with the help of the Cigna Healthcare Pharmacy and Therapeutics (P&T) Committee, which is a group of practicing doctors and pharmacists, most of whom work outside of Cigna Healthcare. The group meets regularly to review medical evidence and information provided by federal agencies, drug manufacturers, medical professional associations, national organizations and peer-reviewed journals about the safety and effectiveness of medications that are newly approved by the FDA and medications already on the market.

The Cigna Healthcare Health Plan Commercial Value Assessment Committee (HVAC) then looks at the results of the P&T Committee's clinical review, as well as the medication's overall value and other factors before adding it to, or removing it from, the drug list.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### **Q. Why do certain medications need approval before my plan will cover them?**

**A.** The review process helps make sure you're getting coverage for the right medication, at the right cost, in the right amount and for the right situation.

#### **Q. How do I know if a medication needs approval?**

**A.** Check your drug list or log in to the myCigna App or **myCigna.com** and use the Price a Medication tool. If the medication has:

- **PA** (Prior Authorization) or **ST** (Step Therapy) next to it, it needs approval before your plan will cover it.
- **QL** (Quantity Limit) next to it, you may need approval depending on how much you're filling at one time.
- **AGE** (Age Requirement) next to it, you may need approval depending on your age.

#### **Q. What types of medications typically need approval?**

**A.** Medications that:

- May not be safe when you take them with other medications.
- Have lower-cost alternatives that work just as well at treating the same condition.
- Should only be used for certain health conditions.
- Are often used in the wrong way or are abused (taken more often than you should).

#### **Q. What types of medications typically have quantity limits?**

**A.** Medications that are often:

- Taken in a greater amount or used for a longer time than they should be.
- Used in the wrong way or are abused (taken more often than you should).

#### **Q. What medications are part of Step Therapy?**

**A.** They're typically high-cost medications that treat conditions such as:

- ADD/ADHD
- Allergies
- Bladder problems
- Breathing problems
- Depression
- High blood pressure
- High cholesterol
- Osteoporosis
- Pain
- Skin conditions
- Sleep disorders

#### **Q. Why does my medication have an age requirement?**

**A.** Not all medications are right for all ages. Some medications work best for people of a certain age or within a certain age range. As you get older, body changes can decrease the body's ability to break down or get rid of certain medications. This means that the medication may stay in your body longer. So, an older adult may need a lower dose of the medication or a different medication that's safer.

#### **Q. How do I get approval (prior authorization) for my medication?**

**A.** Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at **cignaforhcp.com**.

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or **myCigna.com** to see where your medication is in the review process or to read about the decision we made.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication. Also, if you've already received approval for your plan to cover your medication, we can't limit or exclude coverage for that medication if your doctor continues to prescribe it to treat your condition (as long as the medication is appropriately prescribed and is safe and effective in treating your condition).

**Q. My plan doesn't cover my medication. I need to take it because it's medically necessary for my treatment. How do I get approval (prior authorization) for my medication?**

**A.** If your doctor feels that your medication is necessary for your treatment and an alternative isn't right for you, your doctor can ask us to consider approving coverage of your medication. Ask your doctor's office to contact us to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at [cignaforhcp.com](http://cignaforhcp.com).

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or [myCigna.com](http://myCigna.com) to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. **It's important to know that when medications are approved, it's typically for one year of coverage.** If your medication is approved for less time, it's because there's a clinical reason based on our coverage rules (requirements) for the medication and/or the reviewing doctor.

**Q. My medication is part of the Step Therapy program. I don't want to try an alternative. How do I get approval (prior authorization) for my medication?**

**A.** If you and your doctor feel an alternative medication won't work for you, your doctor can ask us to consider approving coverage of your current medication. Ask your doctor's office to contact us

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

to start the coverage review process. They know how the review process works and will take care of everything for you. In case the office asks, they can download a request form from our provider portal at [cignaforhcp.com](http://cignaforhcp.com).

We'll review the information your doctor sends us to make sure you meet the medication's coverage rules (requirements). We'll send you and your doctor a letter with our decision (approved/not approved) and next steps. It can take up to five (5) business days to hear from us. You can always check with your doctor's office to find out if we've made a decision. Or, you can log in to the myCigna App or [myCigna.com](http://myCigna.com) to see where your medication is in the review process or to read about the decision we made.

Many times, we don't get all of the information we need from the doctor's office to approve coverage. If we don't approve your medication, your doctor can send us more information to review, using the same process as before. We're happy to review the request again. Depending on what your doctor sends this time, we may be able to approve coverage. Or you and your doctor can appeal the decision by sending us a request, in writing, that explains why we should cover the medication.

- **For non-urgent requests**, we'll let you and your doctor know within 72 hours of the decision. If approved, coverage will be provided until the prescription runs out (including refills).
- **For urgent requests based on exigent circumstances**, we'll let you and your doctor know within 24 hours of the decision. If approved, coverage will be provided for the duration of the exigency. If we don't respond to a completed prior authorization exception request within 72 hours of receiving a non-urgent request and 24 hours of receiving a request based on exigent circumstances, the request will be considered approved and your plan can't deny coverage of the medication.

### Your Step Therapy rights under California State law:

1. A carrier may impose prior authorization requirements on prescription drug benefits.
2. When there is more than one drug that is appropriate for the treatment of a medical condition, a carrier may require step therapy.
  - a. In circumstances where an insured is changing policies, the new policy shall not require a repeat of step therapy when that insured is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective. A new policy can impose a prior authorization requirement for the continued coverage of a prescription drug prescribed pursuant to step therapy imposed by the former policy. A new policy must also allow a prescribing provider to prescribe another drug covered by the new policy that is medically appropriate for the insured.
3. A carrier shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

### Q. What happens if I try to fill a prescription that needs approval but I don't get approval ahead of time?

**A.** When your pharmacist tries to fill your prescription, they'll see that the medication needs our approval before it can be covered. Because you didn't get approval ahead of time, your plan won't cover its cost. If that happens, ask your doctor to contact us to start the coverage review process.

You can still fill it (without using your plan/insurance), but you'll pay its full price at the pharmacy counter. And, if you do this, your costs can't be applied to your annual deductible or out-of-pocket maximum.

## Information about this drug list

### Frequently asked questions (FAQs) *(cont.)*

#### **Q. What happens if I try to fill a prescription that has a quantity limit?**

**A.** Your pharmacist will only fill the amount your plan covers. If you want to fill more than what's allowed, your doctor's office can ask us to cover it through our review process.

#### **Q. Are all of the medications on this drug list approved by the FDA?**

**A.** Yes.

#### **Q. Does my plan cover medications that the FDA recently approved?**

**A.** We review all recently approved medications and products to see if they should be covered, and if so, at what cost-share (tier). These include, but are not limited to, medications, medical supplies and/or devices covered under standard pharmacy benefits. It can take up to six months from the date the FDA approved them for us to make a decision.

If your doctor wants you to use a recently approved medication, your doctor's office can ask us to cover it through our review process.

#### **Q. What are preventive medications?**

**A.** Preventive medications can help keep you from getting certain long-term health conditions such as asthma, depression, diabetes, heart attack, high blood pressure, high cholesterol, osteoporosis (a disease that causes bones to become weak), prenatal nutrient deficiency (when a pregnant person doesn't get enough of the nutrients they need) and stroke. They improve your chances of staying well and living longer.

#### **Q. Which medications are covered under the health care reform law?**

**A.** The Patient Protection and Affordable Care Act (PPACA), also known as health care reform, helps make health care and preventive care more affordable. PPACA requires health plans to cover the full cost of certain preventive medications and over-the-counter (OTC) products. This means you don't have to pay anything – not even a copay, coinsurance or deductible for these products.

To see a list of \$0 medications, go to **Cigna.com/PDL** and click on the dropdown next to "Drug Lists for Employer Plans." Under the Preventive Drug Lists section, click on the link for the PPACA No Cost-Share Preventive Drug List.

#### **Q. I see several medications on this drug list that can be used to treat my condition. Will my doctor write me a prescription for all of them?**

**A.** No. Just because a medication is listed on your plan's drug list doesn't mean your doctor will write you a prescription for it. Your doctor will work with you to find the medication he or she feels is best for your specific treatment.

#### **Q. How can I find out how much I'll pay for a specific medication?**

**A.** When you and your doctor are thinking about the right medication for your treatment, knowing how much it costs, what lower-cost options are available, and which pharmacies have the best prices can help you avoid surprises. Log in to the myCigna App or **myCigna.com** and use the Price a Medication tool to see how much your medication costs before you get to the pharmacy counter – or even before you leave your doctor's office.<sup>3</sup>

#### **Q. What's a cost-share?**

**A.** It's the amount you pay out of your own pocket for a covered prescription and/or an eligible health care or related service. For some plans, the cost-share is a copay; for other plans, it's a coinsurance.

#### **Q. How can I save money on my prescription medications?**

**A.** You should think about using a medication that's covered on a lower tier, such as a generic or preferred brand medication, or by filling a 90-day supply (if your plan allows). Ask your doctor if one of these options may work for you.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### Q. What's a generic medication?

A. A generic is the same as its brand-name version. It has the same active ingredient, strength and dosage form, treats the same condition(s), and works in the same way – and typically costs less.<sup>4</sup> Generics are typically sold under their chemical or scientific name, instead of the brand name.

#### Q. Do generics work the same as brand-name medications?

A. Yes. A generic medication works in the same way and provides the same clinical benefit as the brand-name medication.<sup>4</sup>

#### Q. What are the differences between generic and brand-name medications?

A. The generic and brand-name medication may<sup>4</sup>:

- Look different. For example, generics may have a different shape, size or color than their brand-name versions.
- Have a different flavor and/or different preservatives, come in different packaging and/or with different labeling and may expire at different times.

It's important to know that these differences don't affect how the generic works.

#### Q. What is a "biosimilar" medication?

A. A biosimilar is "highly similar" to its original biologic medication, which is also known as a reference product, that the FDA has already approved. Even though biosimilars aren't identical to the original medication, they're used to treat the same conditions, and provide the same clinical outcomes and treatment benefits. There are no clinical differences in how safe they are to use and how well they work. They also typically cost less.<sup>5</sup>

#### Q. How do I know which pharmacies are in my plan's network?

A. There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale

warehouse stores – all places where you may already shop. And some stores are open 24-hours. To find an in-network pharmacy near you, log in to the myCigna App or **myCigna.com**. Then click on the Prescriptions tab and choose "Find a Pharmacy" from the dropdown list.

#### Q. My pharmacy isn't in my plan's network. Can I continue to fill my prescriptions there?

A. To get the most from your plan coverage, you should use an in-network pharmacy. If your plan offers out-of-network coverage, you'll pay your out-of-network cost-share to fill a prescription there.

#### Q. Do I have to use home delivery to fill my prescription?

A. It depends on your plan. Some plans require you to fill maintenance medications through Express Scripts<sup>®</sup> Pharmacy and/or specialty medications through Accredo<sup>®</sup> Specialty Pharmacy for them to be covered.<sup>6</sup> Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out what your plan requires.

#### Q. Can I fill my prescriptions by mail?

A. Yes, as long as your plan offers home delivery.<sup>6</sup>

#### Fill maintenance medications through Express Scripts Pharmacy

Express Scripts Pharmacy is a convenient option when you're taking a medication on a regular basis to treat an ongoing health condition. It's simple and safe, and saves you trips to the pharmacy. To learn more, go to **Cigna.com/homedelivery**.

- Easily order, manage, track and pay for your medications on your phone or online.
- Get standard shipping at no extra cost.<sup>7</sup>
- Fill up to a 90-day supply at one time.
- Talk with a pharmacist, 24/7.
- Sign up for automatic refills or refill reminders so you don't miss a dose.<sup>8</sup>
- Use a payment plan (if you need it).

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### Here are two easy ways to get started:

1. **Online.** Log in to the myCigna App or **myCigna.com** and click on the Prescriptions tab. Choose My Medications from the dropdown list. Then click the button next to your medication name to move your prescription(s) from your retail pharmacy to home delivery. Or,
2. **By phone.**
  - Call your doctor's office. Ask them to send a 90-day prescription (with refills) to Express Scripts home delivery. Or,
  - Call Express Scripts Pharmacy at **800.835.3784**. They'll contact your doctor's office to get your prescription. Have your ID card, doctor's contact information and medication name(s) ready when you call.

#### Fill specialty medications through Accredo Specialty Pharmacy

If you're using a specialty medication, Accredo's team can help you manage your rare and/or complex medical condition. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy. To learn more, go to **Cigna.com/specialty**.

- Talk with specially-trained pharmacists and nurses, 24/7.
- Get fast shipping at no extra cost.<sup>7</sup>
- Sign up for refills and reminders. Some refills can be done by text.<sup>9</sup>
- Get help paying for your medication (if you need it).
- Manage and track your medications online.

To get started, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST.

#### Q. I take a specialty medication to treat my multiple sclerosis. My plan requires me to fill my medication through Accredo. How do I get started?

**A.** Some plans allow one or more fills at a retail pharmacy before switching to Accredo. Check your plan materials to find out if your plan allows retail fills.

To get started using Accredo, call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST and Saturdays, 7:00 am–4:00 pm CST. Be sure to call them about two weeks before your next refill so they have time to get a new prescription from your doctor's office.

#### Q. I take a specialty medication that can only be filled at certain pharmacies in the United States. How do I fill my prescription?

**A.** Talk with your doctor. He or she should be able to tell you which in-network pharmacies can fill your prescription. Once you find a pharmacy, ask your doctor to send them your prescription.

You may also be able to use Accredo to fill your prescription; they have access to most specialty medications.<sup>6</sup> Call Accredo at **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST, for more information.

#### Q. How do I fill my prescription?

**A.** First, you'll need to get a prescription from your doctor. Then, your doctor can either:

1. **Send it electronically** to the in-network retail pharmacy of your choice, Express Scripts home delivery or Accredo. Or
2. **Give you a paper prescription.** You can bring it to the in-network retail pharmacy of your choice or mail it to Express Scripts Pharmacy or Accredo.

#### Q. How can I get help with my specialty medication?

**A.** Managing a rare and/or complex medical condition isn't easy. Accredo's team of specialty-trained pharmacists and nurses can help. They'll also fill and ship your specialty medication to you, so you don't have to stand in line at the pharmacy.

Go to **Cigna.com/specialty** to learn more about Accredo or call **877.826.7657**, Monday–Friday, 7:00 am–10:00 pm CST or Saturdays, 7:00 am–4:00 pm CST.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### Q. Where can I find more information about my pharmacy benefits?

A. Use the online tools and resources on the myCigna App or **myCigna.com**. You can find out how much your medication costs (and what lower-cost options may be available), see which medications your plan covers, find an in-network pharmacy, ask a pharmacist a question, see your pharmacy claims and coverage details, and more. You can also manage your home delivery orders.

#### Q. How can I find out my cost-share for each tier of the drug list?

A. We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication. Here are three places you can go to find out how much you'll pay for your medication based on the tier it's listed in, including the maximum cost-share amount allowed:

1. **Check your Cigna Healthcare ID card.** It lists your cost-share for Tier 1, Tier 2 and Tier 3 medications.
2. **Log in to the myCigna App or myCigna.com to view your pharmacy coverage information.** You can also use the Price a Medication tool to find out how much your medication may cost you at the different pharmacies in your plan's network.
3. **Check your Summary of Benefits** coverage document.

#### Q. What's the difference between medications covered under the pharmacy benefit and medical benefit?

A. Some medications are covered under the pharmacy benefit, some are covered under the medical benefit and others are covered under both benefits. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to learn more about how your plan covers your medication.

- Medications that you fill at the pharmacy and take yourself are typically covered under the pharmacy benefit.

- Medications that are injected or infused and are given to you at a doctor's office, hospital, an infusion center or at home are typically covered under the medical benefit.

**Why this matters:** Which benefit the medication's covered under may affect how much it costs, if it needs approval from Cigna Healthcare before your plan will cover it and/or if you have to fill it through a certain pharmacy to be covered. Check your medical summary of benefits coverage to learn more about how your plan covers your medication.

#### Q. I take an oral cancer medication. How much will it cost me to fill?

A. On January 1, 2015, California passed a bill limiting the cost-share for oral chemotherapy medications. This means that if you have both your medical and pharmacy benefits through Cigna Healthcare, here's how certain oral cancer medications are covered:

- **For copay plans:** These medications will be covered at 100%, or no cost-share (\$0) to you.
- **For high deductible health plans (HDHPs) that include a Health Savings Account (HSA) or qualified HDHPs:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you. This is because of a federal HSA requirement.
- **For plans with a combined deductible [including Health Reimbursements Accounts (HRAs) with a combined deductible]:** You'll pay your plan deductible first. After that, these medications will be covered at 100%, or no cost-share (\$0) to you.
- **For plans with a split deductible [including Health Reimbursements Accounts (HRAs) with a split deductible]:** These medications will be covered at 100%, or no cost-share (\$0) to you.

## Information about this drug list

### Frequently asked questions (FAQs) (cont.)

#### Q. How are medications, devices and FDA-approved diabetic, contraceptive and federally-mandated products covered under the pharmacy benefit?

A. Here is how these products are covered under the pharmacy benefit:

- **Preventive care medications and products covered under the Patient Protection and Affordable Care Act (PPACA), also known as “health care reform:”**
  - **Contraceptives:** Covered at 100%, or no cost-share (\$0) to you. Certain prescription contraceptives are available at their applicable cost-share.
  - **Tobacco cessation products:** Up to two (2) 90-day courses of treatment per plan year are covered at 100%, or no cost-share (\$0) to you. Certain prescription tobacco cessation products are available at their applicable cost-share.
  - **Certain vitamins:** Covered at 100%, or no cost-share (\$0) to you. All other prescription vitamins are available at their applicable cost-share and deductible (if applicable).
- **Certain over-the-counter (OTC) products:** If you have a prescription from your doctor, these are covered at 100%, or no cost-share (\$0) to you. All other OTC products are excluded from coverage.
- **Oral fertility medications:** Covered at their applicable tier cost-share. For some plans, injectable fertility medications are covered under the medical benefit.
- **Generic preventive care medications:** Covered at 100%, or no cost-share (\$0) to you before you meet your deductible. You'll pay your deductible and applicable cost-share to fill a preferred brand and/or non-preferred brand preventive care medication.
- **Diabetic supplies:** Covered at their applicable cost-share.
- **Growth Hormones:** Need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.
- **Vaccines:** Vaccines are now covered under the pharmacy benefit. Not all plans cover vaccines in the same way. Log in to the myCigna App or **myCigna.com**, or check your plan materials, to find out how your specific plan covers them.
- **Compounded medications:** If the medication is more than \$200, you'll need approval from Cigna Healthcare before your plan will cover them (prior authorization). If approved, you'll pay your applicable tier cost-share to fill the medication.

### Words you may need to know

- **Brand name drug:** A drug that is marketed under a proprietary, trademark-protected name. A brand name drug is listed in this formulary in all CAPITAL letters.
- **Coinsurance:** A percentage of the cost of a covered health care benefit that you pay after you have paid the deductible, if a deductible applies to the health care benefit.
- **Copayment:** A fixed dollar amount that you pay for a covered health care benefit after you have paid the deductible, if a deductible applies to the health care benefit.
- **Deductible:** The amount you pay for covered health care benefits that are subject to the deductible before your health insurer begins to pay. If your health insurance policy has a deductible, it may have either one deductible or separate deductibles for medical benefits and prescription drug benefits. After you pay your deductible, you usually pay only a copayment or coinsurance for covered health care benefits. Your insurance company pays the rest.

## Information about this drug list

### Words you may need to know (cont.)

- **Drug tier:** A group of prescription drugs that correspond to a specified cost sharing tier in your health insurance policy. The drug tier in which a prescription drug is placed determines your portion of the cost for the drug.
- **Exception request:** A request for coverage of a non-formulary drug. If you, your designee, or your prescribing health care provider submits a request for coverage of a non-formulary drug, your insurer must cover the non-formulary drug when it is medically necessary for you to take the drug.
- **Exigent circumstances:** When you are suffering from a medical condition that may seriously jeopardize your life, health, or ability to regain maximum function, or when you are undergoing a current course of treatment using a non-formulary drug.
- **Formulary or prescription drug list:** The list of drugs that is covered by your health insurance policy under the prescription drug benefit of the policy.
- **Generic drug:** A drug that is the same as its brand name drug equivalent in dosage, strength, effect, how it is taken, quality, safety, and intended use. A generic drug is listed in this formulary in italicized lowercase letters.
- **Medically Necessary:** Health care benefits needed to diagnose, treat, or prevent a medical condition or its symptoms and that meet accepted standards of medicine. Health insurance usually does not cover health care benefits that are not medically necessary.
- **Non-formulary drug:** A prescription drug that is not listed on this formulary.
- **Out-of-pocket costs:** Your expenses for health care benefits that aren't reimbursed by your health insurance. Out-of-pocket costs include deductibles, copayments, and coinsurance for covered health care benefits, plus all costs for health care benefits that are not covered.
- **Prescribing provider:** A health care provider who can write a prescription for a drug to diagnose, treat, or prevent a medical condition.
- **Prescription:** An oral, written, or electronic order from a prescribing provider authorizing a prescription drug to be provided to a specific individual.
- **Prescription drug:** A drug that by law requires a prescription.
- **Prior Authorization:** A decision by your health insurer that a health care benefit is medically necessary for you. If a prescription drug is subject to prior authorization in this formulary, your prescribing provider must request approval from your health insurer to cover the drug before you fill your prescription. Your health insurer must grant a prior authorization request when it is medically necessary for you to take the drug.
- **Step Therapy:** A specific sequence in which prescription drugs for a particular medical condition must be tried. If a drug is subject to step therapy in this formulary, you may have to try one or more other drugs before your health insurance policy will cover that drug for your medical condition. If your prescribing provider submits a request for an exception to the step therapy requirement, your health insurer must grant the request when it is medically necessary for you to take the drug.
- **Quantity Limits:** For some medications, your plan will only cover up to a certain amount over a certain length of time. For example, 30mg per day for 30 days. Quantity limits help to make sure you're receiving coverage for the right medication, in the right amount, and for the right situation. Your plan will only cover a larger amount if your doctor requests and receives approval from Cigna Healthcare.
- **Age Requirements:** For certain medications, you must be within a specific age range for your plan to cover them. This is because some medications aren't considered clinically appropriate for individuals who aren't within that age range.

## Information about this drug list

### About this drug list

This is a list of the most commonly prescribed medications covered on the Cigna Healthcare Value 3-Tier Prescription Drug List as of January 1, 2026. **The drug list is updated often**; so, not all of the medications your plan covers may be listed here. Also, your plan may not cover all of these medications. Log in to the myCigna App or **myCigna.com** to see which medications your plan covers.

**Important:** Your plan doesn't cover prescription medications that treat allergies (ex. Allegra<sup>®</sup>, Clarinex<sup>®</sup>, Xyzal<sup>®</sup> and generics) and heartburn/stomach acid conditions (ex. Nexium<sup>®</sup>, Prilosec OTC<sup>®</sup> and generics). Instead, you can buy them as over-the-counter (OTC) products at your local pharmacy or retail store without a prescription.

### How to read this drug list

Medications are listed alphabetically by their generic and brand names within their therapeutic category and class.\* You can also find your medication using the index at the end of this drug list.

- The generic version of a brand-name medication is listed in parentheses and all *lowercase italicized* letters next to the brand-name medication.
- If a generic equivalent for a brand-name medication is both available and covered, the generic will be listed separately from the brand-name medication in all *lowercase italicized* letters.
- If a generic equivalent for a brand-name medication isn't available on the market or isn't covered, the medication won't be listed separately by its generic version.
- If a generic medication is marketed under a proprietary, trademark-protected brand name, the brand-name medication will be listed after the generic version in parentheses and regular typeface with the first letter of each word capitalized. For example: *quinapril hcl* (Accupril).

### Tiers

We put covered medications into tiers (or cost-share levels). Typically, the higher the tier, the higher the price you'll pay for the medication.

<b>Tier 1</b>	<b>Generics. These medications are covered at your plan's lowest cost-share.</b> Generics work in the same way and provide the same clinical benefits as their brand-name versions – and typically cost much less. <sup>4</sup>	\$
<b>Tier 2</b>	<b>Preferred Brands.</b> These medications typically have one or more lower-cost generic that treats the same condition.	\$\$
<b>Tier 3</b>	<b>Non-Preferred Brands. These medications are covered at your plan's highest cost-share.</b> Non-preferred brands typically have a generic and/or preferred brand alternative(s) that treats the same condition.	\$\$\$

\* Medications are listed in the therapeutic category and class provided by First Databank.

## Information about this drug list

### How to read this drug list (cont.)

#### Letters (acronyms) in the Notes column

In this drug list, some medications have **letters (acronyms)** next to them in the Notes column. Here's what they mean.

<b>PA</b>	<b>Prior Authorization*</b> – This medication needs approval from Cigna Healthcare before your plan will cover it. Your doctor's office will have to send us information to review to make sure you meet the medication's coverage rules (requirements).
<b>QL</b>	<b>Quantity Limit*</b> – Your plan will only cover so much of this medication at one time. If your doctor wants you to fill more than what's allowed, your doctor's office can ask us to cover more.
<b>ST</b>	<b>Step Therapy*</b> – This is a high-cost medication that has a lower-cost alternative(s) that treats the same condition. Your plan won't cover this medication until you try at least one preferred medication first (typically a generic or preferred brand) and can show that it didn't work for you.  If your doctor feels a preferred medication isn't right for you, your doctor's office can ask us to cover the higher-cost medication.
<b>AGE</b>	<b>Age Requirement*</b> – Your plan will only cover this medication if you're a certain age or within a certain age range. If you're not within the allowed age range and your doctor wants you to use the medication, your doctor's office can ask us to cover it.
<b>SP</b>	This is a <b>specialty medication</b> , which is used to treat a rare and/or complex medical condition. Some plans have extra coverage rules (requirements) for specialty medications. For example, some may only cover up to a 30-day supply and/or require you to fill it at a preferred specialty pharmacy to be covered.
<b>HD</b>	<b>Home Delivery Medications</b> – Some plans only cover certain maintenance medications if they're filled through home delivery with Express Scripts Pharmacy. Depending on your plan, you may be able to get coverage for one, two or three fills at an in-network retail pharmacy before you have to switch to home delivery.
<b>PPACA</b>	Health care reform under the <b>Patient Protection and Affordable Care Act (PPACA)</b> requires plans to cover the full cost of this preventive medication or product. This means you don't have to pay anything – not even a copay, coinsurance or deductible.
<b>CSL</b>	<b>Oral Cancer Medications Subject to Cost-Share Limits</b> – State law in California limits the cost-share (or amount you pay out-of-pocket) for certain oral chemotherapy medications.

\* Not all plans have extra coverage rules (requirements) on medications. Log in to the myCigna App or myCigna.com, or check your plan materials, to see if yours does.

# Information about this drug list

## How to read this drug list (cont.)

Use the table below to understand how medications are covered on the Cigna Healthcare Value 3-Tier Prescription Drug List.\*

ANALGESICS (Pain Relief and Inflammatory Disease)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
<i>butalbital/acetaminophen</i>	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb-aspirin-caffe 50-325-40</i>	T1	QL (6 tabs/day)
<i>butalbital-asa-caffeine cap</i> (Fiorinal)	T1	QL (6 caps/day)
FIORINAL ( <i>butalbital-aspirin-caffeine</i> )	T3	QL (6 caps/day)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb/acetaminophen/caffeine</i>	T3	
<i>butalb/acetaminophen/caffeine</i> (Esgic)	T3	QL (6 caps/day)
<i>butalb-acetamin-caff 50-300-40</i> (Fioricet)	T1	QL (6 caps/day)
<i>butalb-acetamin-caff 50-325-40</i> (Esgic)	T1	QL (6 tabs/day)
ESGIC 50-325-40 MG TABLET ( <i>butalbital-acetaminophen-caffe</i> )	T3	QL (6 tabs/day)
ESGIC CAPSULE ( <i>zebutal</i> )	T3	QL (6 caps/day)
FIORICET ( <i>phrenilin forte</i> )	T1	QL (6 caps/day)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>choline salicyl/mag salicylate</i>	T1	HD
<i>diflunisal</i>	T1	HD
<b>ANTI-MIGRAINE PREPARATIONS</b>		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL (12 tabs/30 days)
CAFERGOT ( <i>ergotamine-caffeine</i> )	T3	QL (40 tabs/28 days)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL (10 amps/30 days)
<i>eletriptan hydrobromide</i>	T1	QL (6 tabs/30 days)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	
<i>ergotamine tartrate/caffeine</i> (Cafergot)	T1	QL (40 tabs/28 days)

**Therapeutic drug category and class** describes the condition the medication is used to treat.

**Coverage requirements and limits** lets you know if your plan has extra requirements before it will cover the medication.

**Drug tier** gives you an idea of how much you may pay for a medication.

**Prescription drug name** is the name of the medication.

Medications are listed in **alphabetical order (A-Z)** within each column.

Brand name medications are in all **CAPITAL** letters.

Generic medications are in **lowercase italics**.

\*This table is just an example. It may not show how these medications are currently covered on this drug list.

## Information about this drug list

### How to find your medication

First, look for the therapeutic category/class your medication is in using the alphabetical list below. Then, go to that page to see the covered medications available to treat the condition.

Condition	Page	Condition	Page
Analgesics (Pain Relief and Inflammatory Disease)	19-22	Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents (Pain Relief and Inflammatory Disease)	47, 48
Analgesics (Urinary Tract Conditions)	22	Anti-Neoplastics (Cancer)	48-57
Anesthetics (Miscellaneous)	23	Anti-Neoplastics (Skin Conditions)	57, 58
Anesthetics (Pain Relief and Inflammatory Disease)	23	Anti-Obesity Drugs (Weight Management)	58, 59
Anesthetics (Urinary Tract Conditions)	23	Anti-Parasitics (Eye Conditions)	59
Anti-Allergy (Allergy and Nasal Sprays)	23	Anti-Parasitics (Infections)	59
Anti-Arthritics (Pain Relief and Inflammatory Disease)	23-26	Anti-Parkinson's Drugs (Parkinson's Disease)	59-61
Anti-Asthmatics (Asthma/COPD/Respiratory)	26-29	Anti-Platelet Drugs (Blood Thinners/Anti-Clotting)	61
Antibiotics (Allergy/Nasal Sprays)	29	Antivirals (Aids/Hiv)	62-64
Antibiotics (Ear Medications)	29	Antivirals (Eye Conditions)	64
Antibiotics (Eye Conditions)	29, 30	Antivirals (Infections)	65, 66
Antibiotics (Infections)	30-35	Antivirals (Skin Conditions)	66
Antibiotics (Skin Conditions)	35, 36	Autonomic Drugs (Allergy/Nasal Sprays)	66, 67
Anti-Coagulants (Blood Thinners/Anti-Clotting)	36-38	Autonomic Drugs (Alzheimer's Disease)	67
Antidotes (Gastrointestinal/Heartburn)	38	Autonomic Drugs (Attention Deficit Hyperactivity Disorder)	67
Antidotes (Substance Abuse)	38, 39	Autonomic Drugs (Blood Pressure/Heart Medications)	68
Anti-Fungals (Eye Conditions)	39	Autonomic Drugs (Urinary Tract Conditions)	68
Anti-Fungals (Feminine Products)	39	Biologicals (Allergy/Nasal Sprays)	68
Anti-Fungals (Infections)	39, 40	Biologicals (Blood Pressure/Heart Medications)	68
Anti-Fungals (Skin Conditions)	40	Biologicals (Miscellaneous)	68
Antihistamine and Decongestant Combination (Allergy/Nasal Sprays)	40, 41	Biologicals (Vaccines)	68-73
Antihistamines (Allergy/Nasal Sprays)	41	Blood (Blood Modifiers/Bleeding Disorders)	73-75
Antihistamines (Eye Conditions)	41	Blood (Blood Thinners/Anti-Clotting)	75
Anti-Hyperglycemics (Diabetes)	41-45	Cardiac Drugs (Blood Pressure/Heart Medications)	75-77
Anti-Infectives (Feminine Products)	45	Cardiovascular (Asthma/COPD/Respiratory)	78
Anti-Infectives (Infections)	45, 46		
Anti-Infectives/Miscellaneous (Miscellaneous)	46, 47		

## Information about this drug list

### How to find your medication (cont.)

Condition	Page	Condition	Page
Cardiovascular (Blood Pressure/ Heart Medications)	78-83	Gastrointestinal (Pain Relief and Inflammatory Disease)	115
Cardiovascular (Cholesterol Medications)	83-86	Hormones (Hormonal Agents)	115-120
CNS Drugs (Alzheimer's Disease)	86	Hormones (Infertility)	120, 121
CNS Drugs (Miscellaneous)	86, 87	Hormones (Miscellaneous)	121
CNS Drugs (Multiple Sclerosis)	87, 88	Hormones (Osteoporosis Products)	121
CNS Drugs (Pain Relief and Inflammatory Disease)	88	Immunosuppressants (Pain Relief and Inflammatory Disease)	121, 122
CNS Drugs (Seizure Disorders)	88-92	Immunosuppressants (Skin Conditions)	122
CNS Drugs (Sleep Disorders/Sedatives)	92	Immunosuppressants (Transplant Medications)	122, 123
Colony Stimulating Factors (Blood Modifiers/ Bleeding Disorders)	93	Miscellaneous Medical Supplies, Devices, Non- Drug (Diabetes)	123-137
Colony Stimulating Factors (Cancer)	93	Miscellaneous Medical Supplies, Devices, Non- Drug (Miscellaneous)	137-144
Contraceptives (Contraception Products)	94, 95	Muscle Relaxants (Pain Relief and Inflammatory Disease)	144, 145
Cough/Cold Preparations (Allergy/Nasal Sprays)	95	Prenatal Vitamins (Nutritional/Dietary)	145-148
Cough/Cold Preparations (Cough/Cold Medications)	95, 96	Psychotherapeutic Drugs (Anxiety/Depression/ Bipolar Disorder)	148-152
DIAGNOSTIC (Diabetes)	96	Psychotherapeutic Drugs (Attention Deficit Hyperactivity Disorder)	152-154
Diagnostic (Miscellaneous)	97-99	Psychotherapeutic Drugs (Schizophrenia/ Anti-Psychotics)	154- 156
Diuretics (Diuretics)	99, 100	Psychotherapeutic Drugs (Sleep Disorders/ Sedatives)	156
EENT Preps (Allergy/Nasal Sprays)	100	Sedative/Hypnotics (Sleep Disorders/Sedatives)	156, 157
EENT Preps (Ear Medications)	100, 101	Skin Preps (Miscellaneous)	158, 159
EENT Preps (Eye Conditions)	101-104	Skin Preps (Pain Relief and Inflammatory Disease)	159
Elect/Caloric/H2O (Cholesterol Medications)	104	Skin Preps (Skin Conditions)	159- 166
Elect/Caloric/H2O (Dental Products)	104, 105	Smoking Deterrents (Smoking Cessation)	166, 167
Elect/Caloric/H2O (Diabetes)	105	Thyroid Prep (Hormonal Agents)	167
Elect/Caloric/H2O (Miscellaneous)	105	Unclassified Drug Products (Aids/Hiv)	167
Elect/Caloric/H2O (Nutritional/Dietary)	105- 108	Unclassified Drug Products (Asthma/COPD/ Respiratory)	168, 169
Elect/Caloric/H2O (Urinary Tract Conditions)	108, 109	Unclassified Drug Products (Blood Modifiers/ Bleeding Disorders)	169
Gastrointestinal (Cholesterol Medications)	109		
Gastrointestinal (Gastrointestinal/Heartburn)	109-114		

## Information about this drug list

### How to find your medication (cont.)

Condition	Page	Condition	Page
Unclassified Drug Products (Blood Pressure/ Heart Medications)	169	Unclassified Drug Products (Pain Relief and Inflammatory Disease)	175
Unclassified Drug Products (Cancer)	169	Unclassified Drug Products (Skin Conditions)	175, 176
Unclassified Drug Products (Dental Products)	169	Unclassified Drug Products (Substance Abuse)	176
Unclassified Drug Products (Erectile Dysfunction)	169, 170	Unclassified Drug Products (Transplant Medications)	176
Unclassified Drug Products (Eye Conditions)	170	Unclassified Drug Products (Urinary Tract Conditions)	176, 177
Unclassified Drug Products (Gastrointestinal/ Heartburn)	170	Unclassified Drug Products (Weight Management)	177, 178
Unclassified Drug Products (Hormonal Agents)	170, 171	Vitamins (Nutritional/Dietary)	178- 180
Unclassified Drug Products (Miscellaneous)	171-174		
Unclassified Drug Products (Nutritional/Dietary)	174, 175		
Unclassified Drug Products (Osteoporosis Products)	175		

# List of Prescription Medications

## ANALGESICS (Pain Relief and Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANALGESIC, NON-SALICYLATE AND BARBITURATE COMBINAT</b>		
<i>butalbital/acetaminophen</i>	T1	
<i>butalbital-acetaminophn 50-325</i>	T1	
<b>ANALGESIC, SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalbital-aspirin-caffeine cp</i>	T1	QL(6 CAPS/DAY)
<i>butalbital-aspirin-caffeine tb</i>	T1	QL(6 TABS/DAY)
<b>ANALGESIC, NON-SALICYLATE, BARBITURATE, XANTHINE COMB.</b>		
<i>butalb/acetaminophen/caffeine (Esgic)</i>	T3	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-300-40 (Fioricet)</i>	T1	QL(6 CAPS/DAY)
<i>butalb-acetamin-caff 50-325-40</i>	T1	QL(6 TABS/DAY)
<i>butalb-acetamin-caff 50-325-40 (Esgic)</i>	T1	QL(6 CAPS/DAY)
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
<i>diflunisal</i>	T1	HD
<b>ANTI-MIGRAINE PREPARATIONS</b>		
AIMOVIG AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR	T2	PA
AJOVY AUTOINJECTOR (3 PACK)	T2	PA
AJOVY SYRINGE	T2	PA
<i>almotriptan malate</i>	T1	QL (12 TABS/30 DAYS)
<i>dihydroergotamine 1 mg/ml amp</i>	T1	QL
<i>eletriptan hydrobromide (Relpax)</i>	T1	QL(6 TABS/30 DAYS)
EMGALITY PEN	T2	PA
EMGALITY SYRINGE	T2	PA
<i>ergotamine tartrate/caffeine</i>	T1	QL (40 TABS/28 DAYS)
<i>frovatriptan succinate (Frova)</i>	T1	QL(18 TABS/30 DAYS)
<i>naratriptan hcl</i>	T1	QL (9 TABS/30 DAYS)
NURTEC ODT	T2	PA QL (16 TABS/30 DAYS)
QULIPTA	T2	PA QL(1 TAB/DAY)
<i>rizatriptan benzoate</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt Mlt)</i>	T1	QL(12 TABS/30 DAYS)
<i>rizatriptan benzoate (Maxalt)</i>	T1	QL(12 TABS/30 DAYS)
<i>sumatriptan</i>	T1	QL(12 UNITS/30 DAYS)
<i>sumatriptan 4 mg/0.5 ml cart (Imitrex)</i>	T1	QL (4ML/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MIGRAINE PREPARATIONS (cont.)</b>		
sumatriptan 6 mg/0.5 ml vial	T1	QL (5ML/30 DAYS)
sumatriptan 6 mg/0.5ml autoinj (Imitrex)	T1	QL(4 MLS/30 DAYS)
sumatriptan succ 100 mg tablet (Imitrex)	T1	QL (9 TABS/30 DAYS)
sumatriptan succ 25 mg tablet (Imitrex)	T1	QL (9 TABS/30 DAYS)
sumatriptan succ 50 mg tablet (Imitrex)	T1	QL (9 TABS/30 DAYS)
sumatriptan succ/naproxen sod (Treximet)	T1	QL(18 TABS/30 DAYS)
UBRELVY	T2	PA QL (0.67 TABS/DAY)
ZAVZPRET	T2	PA QL(6 UNITS/30 DAYS)
zolmitriptan	T1	QL(6 TABS/30 DAYS)
zolmitriptan 2.5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
zolmitriptan 5 mg tablet (Zomig)	T1	QL(6 TABS/30 DAYS)
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR-TYPE ANALGESICS</b>		
diclofenac pot 50 mg tablet	T1	HD
diclofenac potassium	T1	HD
ketorolac 10 mg tablet	T1	QL(20 TABS/30 DAYS)
ketorolac 15 mg/ml syringe	T1	QL(8 MLS/DAY)
ketorolac 15 mg/ml vial	T1	QL(8 MLS/DAY)
ketorolac 30 mg/ml syringe	T1	QL(4 MLS/DAY)
ketorolac 30 mg/ml vial	T1	QL(4 MLS/DAY)
ketorolac 300 mg/10 ml vial	T1	
ketorolac 60 mg/2 ml syringe	T1	QL(4 MLS/DAY)
ketorolac 60 mg/2 ml vial	T1	QL(4 MLS/DAY)
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS</b>		
acetamin-codein 300-30 mg/12.5	T1	
acetaminop-codeine 120-12 mg/5	T1	
acetaminophen-cod #2 tablet	T1	PA
acetaminophen-cod #3 tablet	T1	PA
acetaminophen-cod #4 tablet	T1	PA
hydrocodone/acetaminophen	T1	PA
hydrocodone/acetaminophen (Lortab)	T1	PA
HYDROCODONE-ACETAMINOPHEN	T1	PA
LORTAB (hydrocodone/acetaminophen)	T1	PA
NALOCET	T1	PA
oxycodone hcl/acetaminophen	T1	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESIC AND NON-SALICYLATE ANALGESICS (cont.)</b>		
<i>oxycodone hcl/acetaminophen</i> (Percocet)	T1	PA
PRIMLEV	T1	PA
<i>prolata 10-300 mg tablet</i>	T1	PA
<i>prolata 5-300 mg tablet</i>	T1	PA
<i>prolata 7.5-300 mg tablet</i>	T1	PA
<i>tramadol hcl/acetaminophen</i>	T1	
<b>OPIOID ANALGESIC AND NSAID COMBINATION</b>		
<i>hydrocodone/ibuprofen</i>	T1	PA
<b>OPIOID ANALGESIC AND NON-SALICYLATE XANTHINE COMB (cont.)</b>		
<i>acetaminophen/caff/dihydrocod</i>	T1	PA
TREZIX	T3	PA
<b>OPIOID ANALGESICS</b>		
ACTIQ ( <i>fentanyl citrate</i> )	T3	PA
BELBUCA	T2	QL(2 FILMS/DAY)
<i>buprenorphine</i> (Butrans)	T1	QL(4 PATCHES/28 DAYS)
<i>butorphanol tartrate</i>	T1	PA QL(6 BOTTLES/30 DAYS)
BUTRANS ( <i>buprenorphine</i> )	T3	QL(4 PATCHES/28 DAYS)
<i>codeine sulfate</i>	T1	PA
<i>fentanyl</i>	T1	PA
<i>fentanyl citrate</i>	T1	PA
FENTANYL CITRATE	T3	PA
<i>fentanyl citrate</i> (Actiq)	T1	PA
<i>hydrocodone bitartrate</i>	T1	PA
<i>hydrocodone bitartrate</i> (Hysingla Er)	T1	PA
<i>hydromorphone hcl</i>	T1	PA
<i>hydromorphone hcl</i> (Dilaudid)	T1	PA
HYSINGLA ER ( <i>hydrocodone bitartrate</i> )	T2	PA
LAZANDA	T3	PA
<i>meperidine hcl</i>	T1	PA
<i>methadone hcl</i>	T1	PA
<i>morphine sulfate</i>	T1	PA
<i>morphine sulfate</i> (Ms Contin)	T1	PA
MS CONTIN ( <i>morphine sulfate</i> )	T3	PA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANALGESICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANALGESICS (cont.)</b>		
NUCYNTA	T3	PA
NUCYNTA ER	T3	PA
<i>opium/belladonna alkaloids</i>	T1	PA
OXAYDO	T3	PA
<i>oxycodone hcl (ir) 10 mg, 20 mg tab</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg, 15 mg, 30 mg tab (Roxicodone)</i>	T1	PA
<i>oxycodone hcl (ir) 5 mg cap</i>	T1	PA
<i>oxycodone hcl 100 mg/5 ml conc</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml cup</i>	T1	PA
<i>oxycodone hcl 5 mg/5 ml soln</i>	T1	PA
OXYCODONE HCL ER	T1	PA
<i>oxymorphone hcl</i>	T1	PA
<i>pentazocine hcl/naloxone hcl</i>	T1	PA
ROXYBOND	T3	PA
<i>tramadol hcl 50 mg tablet</i>	T1	QL (8 TABS/DAY)
TRAMADOL HCL 75 MG TABLET	T3	QL (5 TABS/DAY)
<i>tramadol hcl 100 mg tablet</i>	T1	QL (4 TABS/DAY)
<i>tramadol er 100 mg, 200 mg, 300 mg tablet</i>	T1	QL (1 TAB/DAY)
TRAMADOL HCL ER 100 MG, 150 MG, 200 MG, 300 MG CAPSULE	T1	QL (1 CAP/DAY)
<i>tramadol hcl er 100 mg, 200 mg, 300 mg tablet</i>	T1	QL (1 TAB/DAY)
XTAMPZA ER	T2	PA
<b>OPIOID AND SALICYLATE ANALGESICS, BARBIT, XANTHINE</b>		
<i>codeine/butalbital/asa/caffein</i>	T1	PA
<b>OPIOID, NON-SALICYL. ANALGESIC, BARBITUATE, XANTHINE</b>		
<i>butalbit/acetamin/caff/codeine</i>	T1	PA
<i>butalbit/acetamin/caff/codeine (Fioricet With Codeine)</i>	T1	PA
<b>SKELETAL MUSCLE RELAXANT, SALICYLAT, OPIOID ANALGESIC</b>		
<i>carisoprodol/aspirin/codeine</i>	T1	PA
<b>ANALGESICS (Urinary Tract Conditions)</b>		
<b>URINARY TRACT ANALGESIC AGENTS</b>		
ELMIRON	T3	
RIMSO-50	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

ANESTHETICS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENERAL ANESTHETICS, INHALANT</b>		
<i>desflurane</i>	T1	
<i>isoflurane</i>	T1	
<i>sevoflurane</i> (Ultane)	T1	
SUPRANE	T3	
ULTANE ( <i>sevoflurane</i> )	T3	
<b>LOCAL ANESTHETICS</b>		
<i>lidocaine hcl</i>	T1	
<b>ANESTHETICS (Pain Relief and Inflammatory Disease)</b>		
<b>TOPICAL LOCAL ANESTHETICS</b>		
<i>lidocaine 5% ointment</i>	T1	QL (145GM/30 DAYS)
<i>lidocaine 5% patch</i> (Lidoderm)	T1	
<i>lidocaine 5% patch</i> (Lidocan li)	T1	
<i>lidocaine hcl</i>	T3	
<i>lidocaine/prilocaine</i>	T1	
ZTLIDO	T2	
<b>ANESTHETICS (Urinary Tract Conditions)</b>		
<b>URINARY TRACT ANESTHETIC/ANALGESIC AGNT (AZO-DYE)</b>		
<i>phenazopyridine hcl</i> (Pyridium)	T1	
<b>ANTI-ALLERGY (Allergy/Nasal Sprays)</b>		
<b>MAST CELL STABILIZERS</b>		
<i>cromolyn 100 mg/5 ml oral conc</i> (Gastrocrom)	T1	
<b>ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease)</b>		
<b>ANALGESIC/ANTIPYRETICS, SALICYLATES</b>		
DISALCID ( <i>salsalate</i> )	T3	HD
<i>salsalate</i> (Disalcid)	T1	HD
<b>ANTI-ARTHRITIC AND CHELATING AGENTS</b>		
DEPEN ( <i>penicillamine</i> )	T3	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg capsule</i> (Cuprimine)	T1	PA QL(6 CAPS/DAY) SP
<i>penicillamine 250 mg tablet</i> (Depen)	T1	PA QL(6 CAPS/DAY) SP
<b>ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS</b>		
OTREXUP	T2	PA

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR</b>		
<i>leflunomide</i> (Arava)	T1	HD
<b>ANTI-INFLAMMATORY, PHOSPHODIESTERASE-4(PDE4) INHIB.</b>		
OTEZLA 10-20 MG STARTER 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 10-20-30 MG START 28 DAY	T2	PA QL(55 TABS/365 DAYS) SP HD
OTEZLA 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP HD
OTEZLA 30 MG TABLET	T2	PA QL (2 TABS/DAY) SP HD
OTEZLA XR 75 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
OTEZLA XR INITIATION PK 28 DAY	T2	PA QL(41 TABS/365 DAYS) SP HD
<b>ANTI-INFLAMMATORY, SEL.COSTIM.MOD., T-CELL INHIBITOR</b>		
ORENCIA	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
ORENCIA CLICKJECT	T3	PA QL(4 SYR/AUTO-INJ/28 DAYS) SP HD
<b>COLCHICINE</b>		
<i>colchicine 0.6 mg capsule</i> (Mitigare)	T1	HD
<i>colchicine 0.6 mg tablet</i> (Colcrys)	T1	HD
MITIGARE (colchicine)	T2	HD
<b>HYPERURICEMIA TX - XANTHINE OXIDASE INHIBITORS</b>		
<i>allopurinol 100 mg tablet</i> (Zyloprim)	T1	HD
<i>allopurinol 300 mg tablet</i>		HD
<i>febuxostat 40 mg tablet</i> (Uloric)	T1	QL(1 TAB/DAY) HD
<i>febuxostat 80 mg tablet</i> (Uloric)	T1	HD
<b>JANUS KINASE (JAK) INHIBITORS</b>		
OLUMIANT	T3	PA QL(30 TABS/30 DAYS) SP HD
RINVOQ	T2	PA QL(1 TAB/DAY) SP HD
RINVOQ LQ	T2	PA QL(12 MLS/DAY) SP HD
XELJANZ 1 MG/ML SOLUTION	T2	PA QL(480 MLS/30 DAYS) SP HD
XELJANZ 10 MG TABLET	T2	PA QL (2 TABS/DAY) SP HD
XELJANZ 5 MG TABLET	T2	PA QL (2 TABS/DAY) SP HD
XELJANZ XR	T2	PA QL (1 TAB/DAY) SP HD
<b>NSAIDS AND TOPICAL IRRITANT COUNTER-IRRITANT COMB.</b>		
COMFORT PAC-IBUPROFEN	T3	
COMFORT PAC-MELOXICAM	T3	
COMFORT PAC-NAPROXEN	T3	

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS(COX NON-SPEC.INHIB) AND PROSTAGLANDIN ANALOG</b>		
ARTHROTEC 50 ( <i>diclofenac sodium/misoprostol</i> )	T3	ST HD
ARTHROTEC 75 ( <i>diclofenac sodium/misoprostol</i> )	T3	ST HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 50)	T1	HD
<i>diclofenac sodium/misoprostol</i> (Arthrotec 75)	T1	HD
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS</b>		
ANAPROX DS ( <i>naproxen sodium</i> )	T3	ST HD
DAYPRO ( <i>oxaprozin</i> )	T3	ST HD
<i>diclofenac sod dr 25, 50, 75 mg tab</i>	T1	HD
<i>diclofenac sod ec 25, 50, 75 mg tab</i>	T1	HD
<i>diclofenac sodium</i>	T1	HD
EC-NAPROSYN ( <i>naproxen</i> )	T3	ST HD
<i>etodolac</i>	T1	HD
<i>etodolac</i> (Lodine)	T1	HD
FELDENE ( <i>piroxicam</i> )	T3	ST HD
<i>fenoprofen 600 mg tablet</i> (Nalfon)	T1	HD
<i>flurbiprofen</i>	T1	HD
<i>ibuprofen</i>	T1	HD
<i>indomethacin 25 mg, 50 mg capsule</i>	T1	HD
<i>indomethacin 25 mg/5 ml susp</i> (Indocin)	T1	HD
<i>indomethacin 50 mg suppository</i> (Indocin)	T1	HD
<i>ketoprofen 50 mg, 75 mg capsule</i>	T1	HD
<i>ketoprofen er 200 mg capsule</i>	T1	HD
LODINE ( <i>etodolac</i> )	T3	ST HD
<i>meclofenamate sodium</i>	T1	HD
<i>meloxicam</i> (Mobic)	T1	HD
<i>meloxicam 7.5 mg, 15 mg tablet</i>	T1	HD
<i>nabumetone</i> (Relafen)	T1	HD
NALFON 600 MG TABLET ( <i>fenoprofen calcium</i> )	T3	ST HD
NAPROSYN 500 MG TABLET ( <i>naproxen</i> )	T3	ST HD
<i>naproxen</i> (Ec-naprosyn)	T1	HD
<i>naproxen 250 mg, 375 mg tablet</i>	T1	HD
<i>naproxen 500 mg kit</i> (Naprosyn)	T1	HD
<i>naproxen 500 mg tablet</i> (Naprosyn)	T1	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-ARTHRITICS (Pain Relief and Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NSAIDS, CYCLOOXYGENASE INHIBITOR- TYPE ANALGESICS (cont.)</b>		
<i>naproxen dr 375 mg tablet (Ec-Naprosyn)</i>	T1	HD
<i>naproxen dr 500 mg tablet (Ec-Naprosyn)</i>	T1	HD
<i>naproxen sodium</i>	T1	HD
<i>naproxen sodium (Anaprox Ds)</i>	T1	HD
<i>oxaprozin 600 mg caplet (Daypro)</i>	T1	HD
<i>oxaprozin 600 mg tablet (Daypro)</i>	T1	HD
<i>piroxicam</i>	T1	HD
<i>piroxicam (Feldene)</i>	T1	HD
<i>sulindac</i>	T1	HD
<i>tolmetin sodium</i>	T1	HD
<i>tolmetin sodium (Tolectin 600)</i>	T1	HD
<b>NSAIDS, CYCLOOXYGENASE-2(COX-2) SELECTIVE INHIBITOR</b>		
<i>celecoxib 100 mg capsule (Celebrex)</i>	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 200 mg capsule (Celebrex)</i>	T1	QL(2 CAPS/DAY) HD
<i>celecoxib 400 mg capsule (Celebrex)</i>	T1	QL(1 CAP/DAY) HD
<i>celecoxib 50 mg capsule (Celebrex)</i>	T1	QL(2 CAPS/DAY) HD
<b>URICOSURIC AGENTS</b>		
<i>probenecid</i>	T1	HD
<i>probenecid/colchicine</i>	T1	HD
<b>ANTI-ASTHMATICS (Asthma/COPD/Respiratory)</b>		
<b>5-LIPOXYGENASE INHIBITORS</b>		
<i>zileuton</i>	T1	HD
<b>ANTICHOLINERGICS, ORALLY INHALED LONG ACTING</b>		
INCRUSE ELLIPTA	T2	HD
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
<i>tiotropium 18 mcg cap-inhaler (Spiriva Handihaler)</i>	T1	HD
<i>tiotropium 18 mcg cap-inhaler (Spiriva Handihaler)</i>	T1	QL(1 INHALER/30 DAYS) HD
<b>ANTICHOLINERGICS, ORALLY INHALED SHORT ACTING</b>		
ATROVENT HFA	T2	QL(2 INHALERS/30 DAYS) HD
<i>ipratropium bromide</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS</b>		
<i>albuterol 2 mg/5 ml syrup cup</i>	T1	HD
<i>albuterol 8 mg/20 ml syrup cup</i>	T1	HD
<i>albuterol sulf 2 mg/5 ml syrup</i>	T1	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AGENTS (cont.)</b>		
<i>albuterol sulfate 2 mg, 4 mg tab</i>	T1	HD
<i>albuterol sulfate er 4 mg, 8 mg tab</i>	T1	HD
<i>terbutaline sulfate</i>	T1	HD
<b>BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING</b>		
<i>albuterol 100 mg/20 ml soln</i>	T1	
<i>albuterol 15 mg/3 ml solution</i>	T1	
<i>albuterol 2.5 mg/0.5 ml sol</i>	T1	
<i>albuterol 25 mg/5 ml solution</i>	T1	
<i>albuterol 5 mg/ml solution</i>	T1	
<i>albuterol 75 mg/15 ml soln</i>	T1	
<i>albuterol hfa 90 mcg inhaler</i>	T1	QL(1 INHALER/30 DAYS)
<i>albuterol sul 0.63 mg/3 ml sol</i>	T1	
<i>albuterol sul 1.25 mg/3 ml sol</i>	T1	
<i>albuterol sul 2.5 mg/3 ml soln</i>	T1	
<i>levalbuterol hcl (Xopenex Concentrate)</i>	T1	
<i>levalbuterol hcl (Xopenex)</i>	T1	
XOPENEX ( <i>levalbuterol hcl</i> )	T3	
XOPENEX CONCENTRATE ( <i>levalbuterol hcl</i> )	T3	
<b>BETA-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING</b>		
STRIVERDI RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
<b>BETA-ADRENERGIC AGENTS, ORALLY INHALED, LONG ACTING</b>		
<i>arformoterol tartrate (Brovana)</i>	T1	QL(4 MLS/DAY) HD
<i>formoterol fumarate (Perforomist)</i>	T1	QL(240 MLS/30 DAYS) HD
<b>BETA-ADRENERGIC AND ANTICHOLINERGIC COMBO, INHALED</b>		
ANORO ELLIPTA 62.5-25 MCG INH	T2	QL(1 INHALER/30 DAYS) HD
COMBIVENT RESPIMAT	T2	QL
<i>ipratropium/albuterol sulfate</i>	T2	HD
STIOLTO RESPIMAT	T2	QL(1 INHALER/30 DAYS) HD
<b>BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED</b>		
AIRSUPRA	T2	QL(2 GMS/28 DAYS) HD
<i>budesonide/formoterol fumarate (Symbicort)</i>	T1	QL(1 INHALER/30 DAYS) HD
DULERA 100 MCG-5 MCG INHALER	T2	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BETA-ADRENERGIC AND GLUCOCORTICOID COMBO, INHALED (cont.)</b>		
DULERA 100 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 200 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
DULERA 50 MCG-5 MCG INHALER	T2	QL(1 INHALER/30 DAYS) HD
<i>fluticasone propion/salmeterol</i>	T1	QL(1 INHALER/30 DAYS)
<i>fluticasone-salmeterol</i> 100-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol</i> 250-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
<i>fluticasone-salmeterol</i> 500-50 (Advair Diskus)	T1	QL(1 INHALER/30 DAYS) HD
<b>BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED</b>		
BREZTRI AEROSPHERE INHALER	T2	QL(1 INHALER/30 DAYS)
TRELEGY ELLIPTA 100-62.5-25	T2	QL(1 BLISTER/30 DAYS)
TRELEGY ELLIPTA 200-62.5-25	T2	QL(1 BLISTER/30 DAYS)
<b>GLUCOCORTICIDS, ORALLY INHALED</b>		
ALVESCO	T2	HD
ASMANEX HFA	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER	T2	QL
ASMANEX TWISTHALER 110 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #14	T2	HD
ASMANEX TWISTHALER 220 MCG #30	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #60	T2	QL(1 INHALER/30 DAYS) HD
ASMANEX TWISTHALER 220 MCG #120	T2	QL(1 INHALER/30 DAYS) HD
<i>budesonide 0.25 mg/2 ml susp</i> (Pulmicort)	T1	QL(4 MLS/DAY) HD
<i>budesonide 0.5 mg/2 ml susp</i> (Pulmicort)	T1	QL(4 MLS/DAY) HD
<i>budesonide 1 mg/2 ml inh susp</i> (Pulmicort)	T1	QL(2 MLS/DAY) HD
QVAR REDIHALER	T2	
<b>INTERLEUKIN-5(IL-5) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
FASENRA PEN	T2	PA SP HD
<b>INTERLEUKIN-5 (IL-5) ANTAGONISTS, MAB</b>		
NUCALA	T2	PA SP HD

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-ASTHMATICS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LEUKOTRIENE RECEPTOR ANTAGONISTS</b>		
ACCOLATE (zafirlukast)	T3	HD
montelukast sodium	T1	HD
montelukast sodium (Singulair)	T1	HD
zafirlukast (Accolate)	T1	HD
<b>MAST CELL STABILIZERS, ORALLY INHALED</b>		
cromolyn 20 mg/2 ml neb soln	T1	QL(480 MLS/30 DAYS) HD
<b>MONOCLONAL ANTIBODIES TO IMMUNOGLOBULIN E (IGE)</b>		
XOLAIR	T2	PA SP HD
<b>MUCOLYTICS</b>		
acetylcysteine	T1	
<b>PHOSPHODIESTERASE (PDE) INHIBITORS</b>		
roflumilast 250 mcg tablet (Daliresp)	T1	QL(28 TABS/180 DAYS) HD
roflumilast 500 mcg tablet (Daliresp)	T1	QL(2 TABS/DAY) HD
<b>XANTHINES</b>		
THEO-24	T3	HD
theophylline anhydrous	T1	HD
<b>ANTIBIOTICS (Ear Medications)</b>		
<b>EAR PREPARATIONS, ANTIBIOTICS</b>		
ciprofloxacin hcl	T1	
CORTISPORIN-TC	T3	
neomycin/polymyxin b/hydrocort	T1	
ofloxacin	T1	
<b>OTIC PREPARATIONS, ANTI-INFLAMMATORY-ANTIBIOTICS</b>		
ciprofloxacin hcl/dexameth	T1	
ciprofloxacin/hydrocortisone	T1	
OTOVEL	T3	
<b>ANTIBIOTICS (Eye Conditions)</b>		
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS</b>		
neomycin/bacit/p-myx/hydrocort	T1	
neomycin/polymyxin b/dexametha (Maxitrol)	T1	
neomycin/polymyxin b/hydrocort	T1	
TOBRADEX	T3	

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## List of Prescription Medications

### ANTIBIOTICS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE ANTIBIOTIC AND GLUCOCORTICOID COMBINATIONS (cont.)</b>		
TOBRADEX ST	T2	
<i>tobramycin/dexamethasone</i>	T1	
ZYLET	T3	
<b>EYE SULFONAMIDES</b>		
<i>sulfacetamide sodium</i>	T1	
<i>sulfacetamide/prednisolone sp</i>	T1	
<b>OPHTHALMIC ANTIBIOTICS</b>		
AZASITE	T2	
<i>bacitracin</i>	T1	
<i>bacitracin/polymyxin b sulfate</i>	T1	
BESIVANCE	T2	
<i>ciprofloxacin hcl</i>	T1	
<i>erythromycin base</i>	T1	
<i>gatifloxacin</i>	T1	
<i>gentamicin sulfate</i>	T1	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>moxifloxacin hcl (Vigamox)</i>	T1	
<i>neomycin/bacitracin/polymyxinb</i>	T1	
<i>neomycin/polymyxn b/gramicidin</i>	T1	
<i>ofloxacin (Ocuflox)</i>	T1	
<i>polymyxin b sulf/trimethoprim</i>	T1	
<i>tobramycin 0.3% eye drop</i>	T1	
<b>ANTIBIOTICS (Infections)</b>		
<b>ABSORBABLE SULFONAMIDE ANTIBACTERIAL AGENTS</b>		
BACTRIM ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
BACTRIM DS ( <i>sulfamethoxazole-trimethoprim</i> )	T3	
<i>sulfadiazine</i>	T1	
<i>sulfamethoxazole/trimethoprim</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim Ds)</i>	T1	
<i>sulfamethoxazole/trimethoprim (Bactrim)</i>	T1	

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HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMINOGLYCOSIDE ANTIBIOTICS</b>		
ARIKAYCE	T3	PA SP
<i>gentamicin sulfate</i>	T1	
<i>gentamicin sulfate/pf</i>	T1	
KITABIS PAK	T3	PA QL(10 MLS/DAY) SP HD
<i>neomycin sulfate</i>	T1	
TOBI PODHALER	T2	PA QL(8 CAPS/DAY) SP HD
<i>tobramycin 1,200 mg/30 ml vial</i>	T1	
<i>tobramycin 1.2 gm vial</i>	T1	PA
<i>tobramycin 1.2 gram/30 ml vial</i>	T1	
<i>tobramycin 20 mg/2 ml vial</i>	T1	
<i>tobramycin 300 mg/4 ml ampule (Bethkis)</i>	T1	QL(8 MLS/DAY) SP HD
<i>tobramycin 300 mg/5 ml ampule (Tobi)</i>	T1	PA QL(10 MLS/DAY) SP HD
<i>tobramycin 40 mg/ml vial</i>	T1	
<i>tobramycin 80 mg/2 ml vial</i>	T1	
TOBRAMYCIN PAK 300 MG/5 ML	T3	PA QL(10 MLS/DAY) SP HD
<b>ANAEROBIC ANTIPROTOZOAL-ANTIBACTERIAL AGENTS</b>		
FLAGYL ( <i>metronidazole</i> )	T3	
LIKMEZ	T3	PA
<i>metronidazole 250 mg tablet</i>	T1	
<i>metronidazole 375 mg capsule (Flagyl)</i>	T1	
<i>metronidazole 500 mg tablet</i>	T1	
<b>ANTIBIOTIC, ANTIBACTERIAL, MISC.</b>		
<i>fosfomycin tromethamine</i>	T1	
<i>methenamine hippurate</i>	T1	
<i>methenamine mandelate</i>	T1	
PRIMSOL	T3	
<i>trimethoprim</i>	T1	
<b>ANTILEPTICS</b>		
<i>dapsone 25 mg tablet</i>	T1	
<i>dapsone 100 mg tablet</i>	T1	
THALOMID	T2	PA SP HD
<b>ANTI-MYCOBACTERIUM AGENTS</b>		
<i>ethambutol hcl</i>	T1	HD

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

## ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-MYCOBACTERIUM AGENTS (cont.)</b>		
<i>isoniazid</i>	T1	HD
PASER	T3	HD
<i>pyrazinamide</i>	T1	HD
<i>rifabutin</i> (Mycobutin)	T1	HD
<b>ANTI-TUBERCULAR ANTIBIOTICS</b>		
<i>cycloserine</i>	T1	
PRETOMANID	T3	PA QL(1 TAB/DAY)
PRIFTIN	T3	
<i>rifampin</i>	T1	
SIRTURO	T3	SP
<b>BETALACTAMS</b>		
CAYSTON	T3	PA QL(3 MLS/DAY) SP HD
<b>CEPHALOSPORIN ANTIBIOTICS - 1ST GENERATION</b>		
<i>cefadroxil</i>	T1	
<i>cephalexin</i>	T1	
<b>CEPHALOSPORIN ANTIBIOTICS - 2ND GENERATION</b>		
<i>cefaclor</i>	T1	
<i>cefprozil</i>	T1	
<i>cefuroxime axetil</i>	T1	
<b>CEPHALOSPORIN ANTIBIOTICS - 3RD GENERATION</b>		
<i>cefdinir</i>	T1	
<i>cefixime</i>	T1	
<i>cefepodoxime proxetil</i>	T1	
<i>ceftriaxone sodium</i>	T1	
<b>LINCOSAMIDE ANTIBIOTICS</b>		
CLEOCIN HCL ( <i>clindamycin hcl</i> )	T3	
CLEOCIN PEDIATRIC ( <i>clindamycin palmitate hcl</i> )	T3	
<i>clindamycin hcl</i> (Cleocin Hcl)	T1	
<i>clindamycin palmitate hcl</i> (Cleocin Pediatric)	T1	

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MACROLIDE ANTIBIOTICS</b>		
<i>azithromycin</i>	T1	
<i>azithromycin</i> (Zithromax Tri-Pak)	T1	
<i>azithromycin</i> (Zithromax)	T1	
<i>clarithromycin</i>	T1	
DIFICID 200 MG TABLET ( <i>fidaxomicin</i> )	T3	QL(28 TABS/28 DAYS)
DIFICID 40 MG/ML SUSPENSION	T3	QL(5 MLS/DAY)
ERYPED 200 ( <i>erythromycin ethylsuccinate</i> )	T3	
ERY-TAB ( <i>erythromycin base</i> )	T3	
<i>erythromycin base</i>	T1	
<i>erythromycin base</i> (Ery-Tab)	T1	
<i>erythromycin ethylsuccinate</i>	T1	
<i>erythromycin ethylsuccinate</i> (E.E.S. 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 200)	T1	
<i>erythromycin ethylsuccinate</i> (Eryped 400)	T1	
<i>erythromycin stearate</i>	T1	
<i>fidaxomicin</i> (Difcid)	T1	QL(28 TABS/28 DAYS)
ZITHROMAX ( <i>azithromycin</i> )	T3	
ZITHROMAX TRI-PAK ( <i>azithromycin</i> )	T3	
<b>NITROFURAN DERIVATIVES ANTIBACTERIAL AGENTS</b>		
FURADANTIN ( <i>nitrofurantoin</i> )	T3	
MACROBID ( <i>nitrofurantoin monohyd/m-cryst</i> )	T3	
<i>nitrofurantoin 25 mg/5 ml susp</i> (Furadantin)	T1	
<i>nitrofurantoin mcr 100 mg cap</i>	T1	
<i>nitrofurantoin mcr 25 mg cap</i>	T1	
<i>nitrofurantoin mcr 50 mg cap</i>	T1	
<i>nitrofurantoin monohyd/m-cryst</i> (Macrobid)	T1	
<b>OXAZOLIDINONE ANTIBIOTICS</b>		
<i>linezolid</i> (Zyvox)	T1	PA
SIVEXTRO	T3	PA
ZYVOX ( <i>linezolid</i> )	T3	PA

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ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PENICILLIN ANTIBIOTICS</b>		
<i>amoxicillin</i>	T1	
<i>amoxicillin/potassium clav</i>	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Es-600)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin Xr)	T1	
<i>amoxicillin/potassium clav</i> (Augmentin)	T1	
<i>ampicillin trihydrate</i>	T1	
<i>dicloxacillin sodium</i>	T1	
MOXATAG	T3	
<i>penicillin v potassium</i>	T1	
<b>PLEUROMUTILIN DERIVATIVES</b>		
XENLETA	T3	PA QL(10 TABS/30 DAYS)
<b>QUINOLONE ANTIBIOTICS</b>		
BAXDELA	T3	PA
CIPRO ( <i>ciprofloxacin hcl</i> )	T3	
CIPRO ( <i>ciprofloxacin</i> )	T3	
<i>ciprofloxacin</i> (Cipro)	T1	
<i>ciprofloxacin hcl</i>	T1	
<i>ciprofloxacin hcl</i> (Cipro)	T1	
FACTIVE	T3	
<i>levofloxacin</i>	T1	
<i>moxifloxacin hcl</i>	T1	
<i>ofloxacin</i>	T1	
<b>RIFAMYCINS AND RELATED DERIVATIVE ANTIBIOTICS</b>		
AEMCOLO	T3	QL(12 TABS/30 DAYS)
XIFAXAN 200 MG TABLET	T2	QL(9 TABS/30 DAYS)
XIFAXAN 550 MG TABLET	T2	QL(42 TABS/30 DAYS)
<b>TETRACYCLINE ANTIBIOTICS</b>		
<i>coremino er 135 mg tablet</i>	T1	
<i>coremino er 45 mg tablet</i>	T1	QL(1 TAB/DAY)
<i>coremino er 90 mg tablet</i>	T1	
<i>demeclocycline hcl</i>	T1	
<i>doxycycline 50 mg tablet</i> (Targadox)	T1	
<i>doxycycline hyclate</i>	T1	

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ST – Step Therapy

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## List of Prescription Medications

### ANTIBIOTICS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TETRACYCLINE ANTIBIOTICS (cont.)</b>		
<i>doxycycline hyclate 100 mg cap</i>	T1	
<i>doxycycline hyclate 100 mg tab (Lymepak)</i>	T1	
<i>doxycycline hyclate 150 mg tab (Acticlate)</i>	T1	
<i>doxycycline hyclate 50 mg cap</i>	T1	
<i>doxycycline hyclate 75 mg tab (Acticlate)</i>	T1	
<i>doxycycline monohydrate</i>	T1	
<i>minocycline er 105 mg tablet</i>	T1	
<i>minocycline er 115 mg tablet (Solodyn)</i>	T1	
<i>minocycline er 135 mg tablet</i>	T1	
<i>minocycline er 45 mg tablet</i>	T1	QL (1 TAB/DAY)
<i>minocycline er 55 mg tablet</i>	T1	
<i>minocycline er 65 mg tablet</i>	T1	
<i>minocycline er 80 mg tablet</i>	T1	
<i>minocycline er 90 mg tablet</i>	T1	
<i>minocycline hcl</i>	T1	
NUZYRA	T3	PA QL (30 TABLETS/28 DAYS) SP
<i>tetracycline 250 mg capsule</i>	T1	
<i>tetracycline 500 mg capsule</i>	T1	
<b>VAGINAL ANTIBIOTICS</b>		
<i>clindamycin phosphate (Cleocin)</i>	T1	
<i>metronidazole</i>	T1	
<i>metronidazole vaginal 0.75% gl</i>	T1	
<b>VANCOMYCIN ANTIBIOTICS AND DERIVATIVES</b>		
<i>vancomycin 25 mg/ml oral soln</i>	T1	
<i>vancomycin 250 mg/5ml oral sol (Firvanq)</i>	T1	
<i>vancomycin 50 mg/ml oral soln (Firvanq)</i>	T1	
<i>vancomycin hcl 125 mg capsule (Vancocin Hcl)</i>	T1	
<i>vancomycin hcl 250 mg capsule (Vancocin Hcl)</i>	T1	
<b>ANTIBIOTICS (Skin Conditions)</b>		
<b>TOPICAL ANTIBIOTIC AND ANTI-INFLAMMATORY STEROID</b>		
NEO-SYNALAR	T3	

T1 – Typically Generics

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T2 – Typically Preferred Brands

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTIBIOTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTIBIOTICS</b>		
BENZAMYCIN ( <i>erythromycin-benzoyl peroxide</i> )	T3	
CENTANY	T3	
CENTANY AT	T3	
CLEOCIN T ( <i>clindamycin phosphate</i> )	T3	
<i>clindamycin phosphate</i>	T1	
<i>clindamycin phosphate</i> (Cleocin T)	T1	
<i>clindamycin phosphate</i> (Clindagel)	T1	
<i>clindamycin phosphate</i> (Evoclin)	T1	
<i>erythromycin base in ethanol</i>	T1	
<i>erythromycin/benzoyl peroxide</i> (Benzamycin)	T1	
EVOCLIN ( <i>clindamycin phosphate</i> )	T3	
<i>gentamicin sulfate</i>	T1	
<i>mupirocin 2% ointment</i>	T1	
XEPI	T3	
<b>TOPICAL SULFONAMIDES</b>		
<i>mafenide acetate</i>	T1	
PLEXION	T3	
SILVADENE ( <i>silver sulfadiazine</i> )	T3	
<i>silver sulfadiazine</i> (Silvadene)	T1	
<i>sulfacetamide sodium/sulfur</i>	T1	
SULFAMYLON	T3	
<b>ANTI-COAGULANTS (Blood Thinners/Anti-Clotting)</b>		
<b>ANTI-COAGULANTS, COUMARIN TYPE</b>		
<i>warfarin sodium</i>	T1	HD
<b>CITRATES AS ANTI-COAGULANTS</b>		
ACD SOLUTION A	T3	
ACD-A SOLUTION	T2	
ANTICOAGULANT SODIUM CITRATE	T3	
CITRATE PHOSPHATE DEXTROSE	T1	
SODIUM CITRATE	T1	
<b>DIRECT FACTOR XA INHIBITORS</b>		
ELIQUIS	T2	

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIRECT FACTOR XA INHIBITORS (cont.)</b>		
ELIQUIS SPRINKLE	T2	
<i>rivaroxaban (Xarelto)</i>	T1	
XARELTO	T2	
XARELTO ( <i>rivaroxaban</i> )	T2	
<b>HEPARIN AND RELATED PREPARATIONS</b>		
ARIXTRA 10 MG/0.8 ML SYRINGE ( <i>fondaparinux sodium</i> )	T3	QL(0.8 ML/DAY) SP
ARIXTRA 2.5 MG/0.5 ML SYRINGE ( <i>fondaparinux sodium</i> )	T3	QL(0.5 ML/DAY) SP
ARIXTRA 5 MG/0.4 ML SYRINGE ( <i>fondaparinux sodium</i> )	T3	QL(0.4 ML/DAY) SP
ARIXTRA 7.5 MG/0.6 ML SYRINGE ( <i>fondaparinux sodium</i> )	T3	QL(0.6 ML/DAY) SP
<i>enoxaparin 100 mg/ml syringe (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 120 mg/0.8 ml syr (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 150 mg/ml syringe (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 30 mg/0.3 ml syr (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 300 mg/3 ml vial (Lovenox)</i>	T1	QL(1 VIAL/DAY) SP
<i>enoxaparin 40 mg/0.4 ml syr (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 60 mg/0.6 ml syr (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>enoxaparin 80 mg/0.8 ml syr (Lovenox)</i>	T1	QL(2 SYRINGES/DAY) SP
<i>fondaparinux 10 mg/0.8 ml syr (Arixtra)</i>	T1	QL(0.8 ML/DAY) SP
<i>fondaparinux 2.5 mg/0.5 ml syr (Arixtra)</i>	T1	QL(0.5 ML/DAY) SP
<i>fondaparinux 5 mg/0.4 ml syr (Arixtra)</i>	T1	QL(0.4 ML/DAY) SP
<i>fondaparinux 7.5 mg/0.6 ml syr (Arixtra)</i>	T1	QL(0.6 ML/DAY) SP
FRAGMIN 10,000 UNIT/4 ML VIAL	T2	QL(1 VIAL/DAY) SP
FRAGMIN 10,000 UNIT/ML SYRINGE	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 12,500 UNIT/0.5 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 15,000 UNIT/0.6 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 18,000 UNIT/0.72 ML	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 2,500 UNIT/0.2 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 5,000 UNIT/0.2 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 7,500 UNIT/0.3 ML SYR	T2	QL(2 SYRINGES/DAY) SP
FRAGMIN 95,000 UNIT/3.8 ML VL	T2	QL(1 VIAL/DAY) SP
<i>heparin 10,000 unit/10 ml vial</i>	T1	
<i>heparin 2,000 unit/2 ml vial</i>	T1	
<i>heparin 30,000 unit/30 ml vial</i>	T1	

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-COAGULANTS (Blood Thinners/Anti-Clotting) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEPARIN AND RELATED PREPARATIONS (cont.)</b>		
<i>heparin 40,000 unit/4 ml vial</i>	T1	
<i>heparin 5,000 unit/ml carpuct</i>	T1	
<i>heparin 50,000 unit/10 ml vial</i>	T1	
<i>heparin 50,000 unit/5 ml vial</i>	T1	
<i>heparin sod 1,000 unit/ml vial</i>	T1	
<i>heparin sod 10,000 unit/ml vl</i>	T1	
<i>heparin sod 20,000 unit/ml vl</i>	T1	
<i>heparin sod 5,000 unit/0.5 ml</i>	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T1	
HEPARIN SOD 5,000 UNIT/0.5 ML	T3	
<i>heparin sod 5,000 unit/ml syrg</i>	T1	
HEPARIN SOD 5,000 UNIT/ML SYRG	T3	
<i>heparin sod 5,000 unit/ml vial</i>	T1	

### THROMBIN INHIBITORS, SELECTIVE, DIRECT, REVERSIBLE

<i>dabigatran etexilate mesylate (Pradaxa)</i>	T1	HD
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### ANTIDOTES (Gastrointestinal/Heartburn)

#### MU-OPIOID RECEPTOR ANTAGONISTS, PERIPHERALLY-ACTING

MOVANTIK	T2	PA
RELISTOR 12 MG/0.6 ML SYRINGE	T3	PA
RELISTOR 12 MG/0.6 ML VIAL	T3	PA
RELISTOR 8 MG/0.4 ML SYRINGE	T3	PA
SYMPROIC	T2	PA

### ANTIDOTES (Substance Abuse)

#### OPIOID ANTAGONISTS

KLOXXADO	T2	QL(2 UNITS/30 DAYS)
<i>naloxone 0.4 mg/ml carpuct</i>	T1	
<i>naloxone 0.4 mg/ml syringe</i>	T1	
<i>naloxone 0.4 mg/ml vial</i>	T1	
<i>naloxone 2 mg/2 ml syringe</i>	T1	
<i>naloxone 4 mg/10 ml vial</i>	T1	
<i>naloxone hcl 4 mg nasal spray (Narcan)</i>	T1	QL(2 UNITS/30 DAYS)
<i>naltrexone hcl</i>	T1	QL(180 TABS/30 DAYS)

T1 – Typically Generics

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T2 – Typically Preferred Brands

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ST – Step Therapy

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## List of Prescription Medications

### ANTIDOTES (Substance Abuse) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTAGONISTS (cont.)</b>		
NARCAN ( <i>naloxone hcl</i> )	T2	QL(2 UNITS/30 DAYS)
OPVEE	T3	QL(2 UNITS/30 DAYS)
REXTOVY	T2	QL(2 UNITS/30 DAYS)
ZIMHI	T3	QL(2 SYRINGES/30 DAYS)

### ANTI-FUNGALS (Eye Conditions)

#### OPHTHALMIC ANTI-FUNGAL AGENTS

NATACYN	T3	
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### ANTI-FUNGALS (Feminine Products)

#### VAGINAL ANTI-FUNGALS

GYNAZOLE 1	T1	
<i>miconazole nitrate</i>	T1	
<i>terconazole</i>	T1	

### ANTI-FUNGALS (Infections)

#### ANTI-FUNGAL AGENTS

ANCOBON ( <i>flucytosine</i> )	T3	
<i>clotrimazole</i>	T1	
CRESEMBA	T3	PA
<i>fluconazole</i>	T1	
<i>fluconazole</i> (Diflucan)	T1	
<i>flucytosine</i> (Ancobon)	T1	
<i>itraconazole</i>	T1	
<i>itraconazole</i> (Sporanox)	T1	
<i>ketoconazole</i>	T1	
NOXAFIL 300 MG POWDERMIX SUSP	T3	
ORAVIG	T3	
<i>posaconazole</i>	T1	
<i>posaconazole</i> (Noxafil)	T1	
<i>terbinafine hcl</i>	T1	
VFEND ( <i>voriconazole</i> )	T3	PA
VIVJOA	T3	PA SP
<i>voriconazole</i> (Vfend)	T1	PA

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## List of Prescription Medications

### ANTI-FUNGALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-FUNGAL ANTIBIOTICS</b>		
<i>griseofulvin ultra 125 mg tab</i>	T1	QL (4 TABS/DAY)
<i>griseofulvin ultra 165 mg tab</i>	T1	
<i>griseofulvin ultra 250 mg tab</i>	T1	
<i>griseofulvin, microsize</i>	T1	
<i>nystatin</i>	T1	

### ANTI-FUNGALS (Skin Conditions)

<b>TOPICAL ANTI-FUNGAL/ANTI-INFLAMMATORY, STEROID AGENT</b>		
<i>clotrimazole/betamethasone dip</i>	T1	
<b>TOPICAL ANTI-FUNGALS</b>		
<i>ciclodan 0.77% cream (Loprox)</i>	T1	
CICLODAN 0.77% CREAM KIT	T3	
CICLODAN 8% KIT	T3	
<i>ciclodan 8% solution</i>	T1	
<i>ciclopirox</i>	T1	
<i>ciclopirox olamine (Loprox)</i>	T1	
<i>ciclopirox/urea/camph/men/euc</i>	T1	
<i>econazole nitrate 1% cream</i>	T1	
ECOZA	T3	
EXODERM	T1	
<i>ketoconazole</i>	T1	
<i>ketoconazole (Extina)</i>	T1	
LOPROX 0.77% SUSPENSION KIT	T3	
LOPROX 0.77% TOPICAL SUSP ( <i>ciclopirox olamine</i> )	T3	
LULICONAZOLE	T1	
<i>naftifine hcl</i>	T1	
<i>naftifine hcl (Naftin)</i>	T1	
NAFTIN ( <i>naftifine hcl</i> )	T3	
<i>nystatin</i>	T1	
<i>nystatin/triamcinolone acet</i>	T1	

### ANTI-HISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays)

<b>1ST GEN ANTI-HISTAMINE AND DECONGESTANT COMBINATION</b>		
<i>phenylephrine hcl/prometh hcl</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTIHISTAMINE AND DECONGESTANT COMBINATION (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>2ND GEN ANTIHISTAMINE AND DECONGESTANT COMBINATION</b>		
CLARINEX-D 12 HOUR	T3	
<b>ANTIHISTAMINES (Allergy/Nasal Sprays)</b>		
<b>ANTIHISTAMINES - 1ST GENERATION</b>		
<i>carbinoxamine 4 mg/5 ml liquid</i>	T1	
<i>carbinoxamine maleate</i>	T1	
<i>carbinoxamine maleate 4 mg tab</i>	T1	
<i>clemastine fum 2.68 mg tablet</i>	T1	
<i>clemastine fumarate</i>	T1	
<i>cyproheptadine hcl</i>	T1	
<i>hydroxyzine hcl</i>	T1	
<i>hydroxyzine pamoate</i>	T1	
<i>hydroxyzine pamoate (Vistaril)</i>	T1	
<i>promethazine hcl</i>	T1	
VISTARIL ( <i>hydroxyzine pamoate</i> )	T3	
<b>ANTIHISTAMINES - 2ND GENERATION</b>		
<i>cetirizine hcl</i>	T1	HD
<i>desloratadine 2.5 mg odt</i>	T1	QL (1 TAB/DAY) HD
<i>desloratadine 5 mg odt</i>	T1	HD
<i>desloratadine 5 mg tablet</i>	T1	HD
<i>levocetirizine dihydrochloride</i>	T1	HD
<b>ANTIHISTAMINES (Eye Conditions)</b>		
<b>EYE ANTIHISTAMINES</b>		
<i>azelastine hcl 0.05% drops</i>	T1	
<i>bepotastine besilate</i>	T1	
<i>epinastine hcl</i>	T1	
<i>olopatadine hcl 0.1% eye drops</i>	T1	
<i>olopatadine hcl 0.2% eye drop</i>	T1	
<b>ANTI-HYPERGLYCEMICS (Diabetes)</b>		
<b>ANTIHYPERGLY, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST)</b>		
BYDUREON BCISE	T2	PA QL(4 MLS/28 DAYS)
<i>exenatide</i>	T1	PA QL(3 MLS/30 DAYS)
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS</b>		
<i>liraglutide 2-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 2-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
<i>liraglutide 3-pak 18 mg/3 ml (Victoza 3-Pak)</i>	T1	PA QL(3 PENS/30 DAYS)
OZEMPIC	T2	PA QL(3 MLS/28 DAYS)
RYBELSUS	T2	PA QL(1 TAB/DAY)
TRULICITY	T2	PA QL(2 MLS/28 DAYS)
<b>ANTI-HYPERGLY, INSULIN, LONG ACT-GLP-I RECEPT.AGONIST</b>		
SOLIQUA 100-33	T2	
<b>ANTI-HYPERGLYCEMIC-DOPAMINE RECEPTOR AGONISTS</b>		
CYCLOSET	T3	HD
<b>ANTI-HYPERGLYCEMIC - INCRETIN MIMETICS COMBINATION</b>		
MOUNJARO 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
MOUNJARO 5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
MOUNJARO 7.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
<b>ANTI-HYPERGLYCEMIC, ALPHA-GLUCOSIDASE INHIBITORS</b>		
<i>acarbose (Precose)</i>	T1	HD
<i>miglitol</i>	T1	HD
PRECOSE ( <i>acarbose</i> )	T3	HD
<b>ANTI-HYPERGLYCEMIC, AMYLIN ANALOG-TYPE</b>		
SYMLINPEN 120	T2	HD
SYMLINPEN 60	T2	
<b>ANTI-HYPERGLYCEMIC, BIGUANIDE TYPE</b>		
<i>metformin hcl</i>	T1	HD
<i>metformin hcl 1,000 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg tablet</i>	T1	HD
<i>metformin hcl 500 mg/5 ml cup (Riomet)</i>	T1	HD
<i>metformin hcl 500 mg/5 ml soln (Riomet)</i>	T1	HD
<i>metformin hcl 750 mg tablet</i>	T1	HD
<i>metformin hcl 850 mg tablet</i>	T1	HD
RIOMET ( <i>metformin hcl</i> )	T3	HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITORS</b>		
JANUVIA	T2	ST QL(1 TAB/DAY) HD
saxagliptin hcl (Onglyza)	T1	QL(1 TAB/DAY) HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIMULANT TYPE</b>		
glimepiride 1 mg tablet	T1	HD
glimepiride 2 mg tablet	T1	HD
GLIMEPIRIDE 3 MG TABLET	T3	HD
glimepiride 4 mg tablet	T1	HD
glipizide (Glucotrol XL)	T1	HD
glipizide 10 mg tablet	T1	HD
GLIPIZIDE 2.5 MG TABLET	T3	HD
glipizide 5 mg tablet	T1	HD
GLUCOTROL XL (glipizide)	T3	HD
glyburide	T1	HD
glyburide,micronized	T1	HD
glyburide,micronized (Glynase)	T1	HD
GLYNASE (glyburide,micronized)	T3	HD
nateglinide	T1	HD
repaglinide	T1	HD
<b>ANTI-HYPERGLYCEMIC, SGLT-2 AND DPP-4 INHIBITOR COMB</b>		
GLYXAMBI	T2	ST QL(1 TAB/DAY) HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE AND BIGUANIDE</b>		
ACTOPLUS MET (pioglitazone hcl/metformin hcl)	T3	HD
pioglitazone hcl/metformin hcl	T1	HD
pioglitazone hcl/metformin hcl (Actoplus Met)	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE-SULFONYLUREA</b>		
DUETACT (pioglitazone-glimepiride)	T3	HD
pioglitazone hcl/glimepiride (Duetact)	T1	HD
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS.</b>		
JANUMET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 100-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
JANUMET XR 50-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
JANUMET XR 50-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
linagliptin/metformin hcl	T1	QL(2 TABS/DAY) HD

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ST – Step Therapy

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## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERGLYCEMIC, DPP-4 INHIBITOR-BIGUANIDE COMBS. (cont.)</b>		
saxagliptin-metformin er 5-500 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptin-metformin er 5-1000 (Kombiglyze Xr)	T1	QL(1 TAB/DAY) HD
saxagliptin-metformin er 2.5-1000 (Kombiglyze Xr)	T1	QL(2 TABS/DAY) HD
<b>ANTI-HYPERGLYCEMIC, INSULIN-RELEASE STIM.-BIGUANIDE</b>		
glipizide/metformin hcl	T1	HD
glyburide/metformin hcl	T1	HD
<b>ANTI-HYPERGLYCEMIC, THIAZOLIDINEDIONE (PPARG AGONIST)</b>		
pioglitazone hcl (Actos)	T1	HD
<b>ANTI-HYPERGLYCEMIC-GLUCOCORTICOID RECEPTOR BLOCKER</b>		
mifepristone 300 mg tablet (Korlym)	T1	PA SP
<b>ANTI-HYPERGLYCEMIC-SGLT2 INHIBITOR-BIGUANIDE COMBS.</b>		
SYNJARDY	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 10-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 12.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
SYNJARDY XR 25-1,000 MG TABLET	T2	ST QL(1 TAB/DAY) HD
SYNJARDY XR 5-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 10 MG-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 10 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
XIGDUO XR 2.5 MG-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-1,000 MG TABLET	T2	ST QL(2 TABS/DAY) HD
XIGDUO XR 5 MG-500 MG TABLET	T2	ST QL(1 TAB/DAY) HD
<b>ANTIHYPERGLYCEMIC-SOD/GLUC COTRANSPORT2(SGLT2) INH</b>		
FARXIGA	T2	ST QL(1 TAB/DAY)
JARDIANCE	T2	ST QL(1 TAB/DAY) HD
<b>ANTIHYPERGLY-SGLT-2 INHIB, DPP-4 INHIB, BIGUANIDE CB</b>		
TRIJARDY XR 10-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 12.5-2.5-1,000 MG	T2	ST QL(2 TABS/DAY) HD
TRIJARDY XR 25-5-1,000 MG TAB	T2	ST QL(1 TAB/DAY) HD
TRIJARDY XR 5-2.5-1,000 MG TAB	T2	ST QL(2 TABS/DAY) HD
<b>INSULINS</b>		
BASAGLAR KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
BASAGLAR TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG	T2	QL(1.5 MLS/DAY) HD
HUMALOG JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD

T1 – Typically Generics

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QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-HYPERGLYCEMICS (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INSULINS (cont.)</b>		
HUMALOG KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMALOG KWIKPEN U-200	T2	QL(1 ML/DAY) HD
HUMALOG MIX 50-50 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25	T2	QL(2 MLS/DAY) HD
HUMALOG MIX 75-25 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMALOG TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
HUMULIN 70/30 KWIKPEN	T2	QL(2 MLS/DAY) HD
HUMULIN 70-30	T2	QL(2 MLS/DAY) HD
HUMULIN N	T2	QL(1.5 MLS/DAY) HD
HUMULIN N KWIKPEN	T2	QL(1.5 MLS/DAY) HD
HUMULIN R	T2	QL(1.5 MLS/DAY) HD
HUMULIN R U-500	T2	QL(1 ML/DAY) HD
HUMULIN R U-500 KWIKPEN	T2	QL(1 ML/DAY) HD
INSULIN LISPRO	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO JUNIOR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
INSULIN LISPRO PROTAMINE MIX	T2	QL(2 MLS/DAY) HD
LYUMJEV	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-100	T2	QL(1.5 MLS/DAY) HD
LYUMJEV KWIKPEN U-200	T2	QL(1 ML/DAY) HD
LYUMJEV TEMPO PEN U-100	T2	QL(1.5 MLS/DAY) HD
REZVOGLAR KWIKPEN	T2	QL(1.5 MLS/DAY) HD
TRESIBA	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-100	T2	QL(1.5 MLS/DAY) HD
TRESIBA FLEXTOUCH U-200	T2	QL(0.9 MLS/DAY) HD

### ANTI-INFECTIVES/MISCELLANEOUS (Feminine Products)

#### VAGINAL ANTISEPTICS

<i>acetic acid/oxyquinoline</i> (Relagard)	T1	
RELAGARD ( <i>acetic acid/oxyquinoline</i> )	T3	
TRIMO-SAN	T3	

### ANTI-INFECTIVES/MISCELLANEOUS (Infections)

#### 2ND GEN. ANAEROBIC ANTI-PROTOZOAL-ANTIBACTERIAL

<i>tinidazole</i>	T1	
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T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-INFECTIVES/MISCELLANEOUS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTHELMINTICS</b>		
<i>albendazole</i>	T1	
BILTRICIDE ( <i>praziquantel</i> )	T3	
EMVERM	T1	
<i>ivermectin 3 mg tablet</i> (Stromectol)	T1	PA
<i>ivermectin 6 mg tablet</i>	T1	PA
<i>praziquantel</i> (Biltricide)	T1	
STROMEKTOL ( <i>ivermectin</i> )	T3	PA
<b>ANTI-MALARIAL DRUGS</b>		
<i>atovaquone/proguanil hcl</i> (Malarone)	T1	
<i>chloroquine phosphate</i>	T1	
COARTEM	T3	PA QL(24 TABS/30 DAYS)
<i>hydroxychloroquine sulfate</i>	T1	
<i>hydroxychloroquine sulfate</i> (Plaquenil)	T1	
KRINTAFEL	T3	PA QL(2 TABS/30 DAYS)
MALARONE ( <i>atovaquone-proguanil hcl</i> )	T3	PA
<i>mefloquine hcl</i>	T1	
PRIMAQUINE ( <i>primaquine phosphate</i> )	T1	
<i>primaquine phosphate</i> (Primaquine)	T1	
<i>pyrimethamine 25 mg tablet</i> (Daraprim)	T1	PA SP
<i>quinine sulfate</i>	T1	
<b>ANTI-PROTOZOAL DRUGS, MISCELLANEOUS</b>		
<i>atovaquone</i> (Mepro) )	T1	
BENZNIDAZOLE	T3	
IMPAVIDO	T3	PA
LAMPIT	T3	
NEBUPENT ( <i>pentamidine isethionate</i> )	T3	
<i>pentamidine isethionate</i> (Nebupent)	T1	
<b>ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous)</b>		
<b>ANTIBACTERIAL AGENTS, MISCELLANEOUS</b>		
<i>glycine urologic solution</i>	T1	

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-INFECTIVES/MISCELLANEOUS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTISEPTICS,GENERAL</b>		
ALCOHOL SWABSTICK	T3	
CVS ISOPROPYL ALCOHOL 91% SPRY	T1	
GS ISOPROPYL ALCOHOL 70% SPRAY	T1	
ISOPROPYL ALCOHOL 70% SPRAY	T1	
MEDI-FIRST ISOPROPYL ALCOHOL	T3	
<b>ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR</b>		
ADALIMUMAB-ADB(M) 10 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 20 MG SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
ADALIMUMAB-ADB(M) 40 MG SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-ADB(M) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF)	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
ADALIMUMAB-RYVK(CF) AUTOINJECT	T2	PA QL SP HD
AVSOLA	T2	PA SP HD
CIMZIA (2 PACK)	T2	PA QL(1 KIT/28 DAYS) SP HD
CIMZIA 200 MG/ML SYRINGE KIT	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP
CIMZIA 2X200 MG/ML(X3)START KT	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) 10 MG/0.2 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 20 MG/0.4 ML SYRNG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.4 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) 40 MG/0.8 ML SYRNG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
CYLTEZO(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
CYLTEZO(CF) PEN PSORIASIS-UV	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
ENBREL 25 MG/0.5 ML SYRINGE	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 25 MG/0.5 ML VIAL	T2	PA QL(8 MLS/28 DAYS) SP HD
ENBREL 50 MG/ML SYRINGE	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL MINI	T2	PA QL(4 MLS/28 DAYS) SP HD
ENBREL SURECLICK	T2	PA QL(4 MLS/28 DAYS) SP HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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## List of Prescription Medications

### ANTI-INFLAM.TUMOR NECROSIS FACTOR INHIBITING AGENTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR (cont.)</b>		
HUMIRA	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA PEN	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) 10 MG/0.1 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 20 MG/0.2 ML SYRING	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
HUMIRA(CF) 40 MG/0.4 ML SYRING	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 40 MG/0.4 ML	T2	PA QL(4 KITS/28 DAYS) SP HD
HUMIRA(CF) PEN 80 MG/0.8 ML	T3	PA QL(2 PENS/28 DAYS) SP HD
HUMIRA(CF) PEN CROHN'S-UC-HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T2	PA QL(1 STARTER KIT/365 DAYS) SP HD
INFLECTRA	T2	PA SP HD
INFLIXIMAB	T2	PA SP HD
REMICADE	T2	PA SP HD
SIMLANDI(CF) 20 MG/0.2 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) 40 MG/0.4 ML SYRG	T2	PA QL(4 SRNGE KITS/28 DAYS) SP HD
SIMLANDI(CF) 80 MG/0.8 ML SYRG	T2	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
SIMLANDI(CF) AI 40 MG/0.4 ML	T2	PA QL SP HD
SIMLANDI(CF) AI 80 MG/0.8 ML	T2	PA QL(2 AUTO-INJS/28 DAYS) SP HD
SIMPONI 100 MG/ML PEN INJECTOR	T2	PA QL(1 PEN/28 DAYS) SP HD
SIMPONI 100 MG/ML SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
SIMPONI ARIA	T2	PA SP HD
<b>ANTI-NEOPLASTICS (Cancer)</b>		
<b>ANP - SELECTIVE RETINOID X RECEPTOR AGONISTS (RXR)</b>		
<i>bexarotene 75 mg capsule (Targretin)</i>	T1	PA SP HD CSL
<b>ANTI-NEOPLAST, HISTONE DEACETYLASE (HDAC) INHIBITORS</b>		
ZOLINZA	T2	PA SP HD
<b>ANTI-NEOPLASTIC - ALKYLATING AGENTS</b>		
<i>ALKERAN (melphalan)</i>	T3	SP CSL
<i>cyclophosphamide 25 mg capsule</i>	T1	SP HD CSL
<i>cyclophosphamide 50 mg capsule</i>	T1	SP HD CSL
GLEOSTINE	T2	CSL
HYDREA (hydroxyurea)	T3	CSL
<i>hydroxyurea (Hydrea)</i>	T1	CSL

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - ALKYLATING AGENTS (cont.)</b>		
LEUKERAN	T2	CSL
<i>lomustine</i>	T1	CSL
MYLERAN	T2	CSL
<i>temozolomide</i>	T1	PA SP HD CSL
<b>ANTI-NEOPLASTIC - ANTI-ANDROGENIC AGENTS</b>		
<i>abiraterone acetate (Zytiga)</i>	T1	PA CSL
<i>abiraterone acetate 250 mg tab (Zytiga)</i>	T1	PA SP HD CSL
<i>abiraterone acetate 500 mg tab (Zytiga)</i>	T1	PA SP HD CSL
<i>bicalutamide (Casodex)</i>	T1	CSL
CASODEX ( <i>bicalutamide</i> )	T3	CSL
ERLEADA	T2	PA SP HD CSL
EULEXIN ( <i>flutamide</i> )	T3	CSL
<i>flutamide (Eulexin)</i>	T1	CSL
<i>nilutamide (Nilandron)</i>	T1	QL(4 TABS/DAY) CSL
NUBEQA	T2	PA SP HD CSL
XTANDI	T2	PA SP HD CSL
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES</b>		
<i>capecitabine 150 mg tablet (Xeloda)</i>	T1	PA SP HD CSL
<i>capecitabine 500 mg tablet (Xeloda)</i>	T1	PA SP HD CSL
INQOVI	T3	PA SP HD CSL
JYLAMVO	T3	CSL
LONSURF	T3	PA SP HD CSL
<i>mercaptopurine 20 mg/ml suspen (Purixan)</i>	T1	SP CSL
<i>mercaptopurine 50 mg tablet</i>	T1	CSL
<i>methotrexate 2.5 mg tablet</i>	T1	CSL
<i>methotrexate 250 mg/10 ml vial</i>	T1	
<i>methotrexate 50 mg/2 ml vial</i>	T1	
<i>methotrexate sodium/pf</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - ANTI-METABOLITES (cont.)</b>		
ONUREG	T3	PA QL(14 TABS/28 DAYS) SP CSL
PURIXAN ( <i>mercaptopurine</i> )	T3	SP CSL
TABLOID	T3	CSL
TREXALL	T2	CSL
XATMEP	T3	CSL
XELODA ( <i>capecitabine</i> )	T3	PA SP HD CSL
<b>ANTI-NEOPLASTIC - AROMATASE INHIBITORS</b>		
<i>anastrozole</i> (Arimidex)	T1	HD PPACA CSL
ARIMIDEX ( <i>anastrozole</i> )	T3	HD CSL
AROMASIN ( <i>exemestane</i> )	T3	HD CSL
<i>exemestane</i> (Aromasin)	T1	HD PPACA CSL
<i>letrozole</i> (Femara)	T1	HD CSL
<b>ANTI-NEOPLASTIC - BRAF KINASE INHIBITORS</b>		
OJEMDA 25 MG/ML ORAL SUSP	T3	PA QL(8 BOTTLES/28 DAYS) SP CSL
OJEMDA 100 MG TAB (400MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (500MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
OJEMDA 100 MG TAB (600MG DOSE)	T3	PA QL(1 PACKET/28 Days) SP CSL
TAFINLAR 10 MG TABLET FOR SUSP	T2	PA QL(30 TABS/DAY) SP HD CSL
TAFINLAR 50 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
TAFINLAR 75 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP HD CSL
ZELBORAF	T2	PA SP HD CSL
<b>ANTINEOPLASTIC - EGFR AND MET RECEPTOR INHIB, MAB</b>		
RYBREVANT	T3	PA SP
<b>ANTI-NEOPLASTIC - HEDGEHOG PATHWAY INHIBITOR</b>		
DAURISMO	T3	PA SP HD CSL
ERIVEDGE	T2	PA SP HD CSL
ODOMZO	T2	PA SP HD CSL
<b>ANTI-NEOPLASTIC - JANUS KINASE (JAK) INHIBITORS</b>		
JAKAFI	T3	PA QL(2 TABS/DAY) SP HD CSL

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

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QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

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# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC - KRAS PROTEIN INHIBITOR</b>		
LUMAKRAS 120 MG TABLET	T3	PA QL(8 TABS/DAY) SP HD CSL
LUMAKRAS 240 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LUMAKRAS 320 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
<b>ANTI-NEOPLASTIC - MEKI AND MEK2 KINASE INHIBITORS</b>		
COTELLIC	T2	PA SP HD CSL
GOMEKLI	T3	PA SP CSL
KOSELUGO 10 MG CAPSULE	T3	PA QL(10 CAPS/DAY) SP CSL
KOSELUGO 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP CSL
KOSELUGO 5 MG SPRINKLE CAPSULE	T3	PA QL(20 CAPS/DAY) SP CSL
KOSELUGO 7.5 MG SPRINKLE CAP	T3	PA QL(12 CAPS/DAY) SP CSL
MEKINIST 0.05 MG/ML SOLUTION	T2	PA QL(40 MLS/DAY) SP HD CSL
MEKINIST 0.5 MG TABLET	T2	PA QL(3 TABS/DAY) SP HD CSL
MEKINIST 2 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD CSL
<b>ANTI-NEOPLASTIC - MTOR KINASE INHIBITORS</b>		
<i>everolimus (Afinitor)</i>	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 10 mg tablet (Afinitor)</i>	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 2 mg tab for susp (Afinitor Disperz)</i>	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 2.5 mg tablet (Afinitor)</i>	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 3 mg tab for susp (Afinitor Disperz)</i>	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tab for susp (Afinitor Disperz)</i>	T1	PA QL(1 TAB/DAY) SP CSL
<i>everolimus 5 mg tablet (Afinitor)</i>	T1	PA QL(1 TAB/DAY) SP HD CSL
<i>everolimus 7.5 mg tablet (Afinitor)</i>	T1	PA QL(1 TAB/DAY) SP HD CSL
FYARRO	T3	PA SP
<b>ANTI-NEOPLASTIC - PROTEIN METHYLTRANSFERASE INHIBIT</b>		
TAZVERIK	T3	PA SP CSL
<b>ANTINEOPLASTIC - SYSTEMIC ENZYME INHIBITORS COMBS</b>		
AVMAPKI-FAKZYNJA	T3	PA SP CSL
<b>ANTI-NEOPLASTIC - TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN	T3	PA SP HD CSL
<b>ANTI-NEOPLASTIC COMB - KINASE AND AROMATASE INHIBIT</b>		
KISQALI FEMARA CO-PACK	T2	PA QL(1 TAB/28 DAYS) SP CSL
<b>ANTI-NEOPLASTIC EGF RECEPTOR BLOCKER MCLON ANTIBODY</b>		
PHESGO	T3	PA SP HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC IMMUNOMODULATOR AGENTS</b>		
<i>lenalidomide</i>	T1	PA QL(1 CAP/DAY) SP HD CSL
POMALYST	T2	PA QL(21 CAPS/28 DAYS) SP HD CSL
REVLIMID	T2	PA QL(1 CAP/DAY) SP HD CSL
<b>ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.</b>		
<i>leuprolide acetate</i>	T1	PA SP HD
LEUPROLIDE DEPOT	T3	PA SP
LUPRON DEPOT 22.5 MG 3MO KIT	T3	PA SP HD
LUPRON DEPOT 45 MG 6MO KIT	T3	PA SP HD
LUPRON DEPOT 7.5 MG KIT	T3	PA SP HD
LUPRON DEPOT-4 MONTH KIT	T3	PA SP HD
LUTRATE DEPOT	T3	PA SP
ZOLADEX	T2	PA SP HD
<b>ANTINEOPLASTIC LHRH(GNRH) ANTAGONIST,PITUIT.SUPPRS</b>		
FIRMAGON	T3	PA SP HD
ORGOVYX	T3	PA SP CSL
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS</b>		
ALECENSA	T2	PA QL(8 CAPS/DAY) SP HD CSL
ALUNBRIG 180 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 30 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
ALUNBRIG 90 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
ALUNBRIG 90 MG-180 MG TAB PACK	T2	PA QL(1 TAB/DAY) SP CSL
AYVAKIT	T3	PA QL(1 TAB/DAY) SP CSL
BALVERSA	T3	PA SP CSL
BOSULIF 100 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 100 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
BOSULIF 50 MG CAPSULE	T3	PA QL(3 CAPS/DAY) SP HD CSL
BOSULIF 500 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD CSL
BRUKINSA 160 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
BRUKINSA 80 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
CABOMETYX	T2	PA SP HD CSL
CALQUENCE	T2	PA SP CSL
CAPRELSA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
CAPRELSA 300 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
COMETRIQ 100 MG DAILY-DOSE PK	T3	PA QL(56 CAPS/28 DAYS) SP HD CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
COMETRIQ 140 MG DAILY-DOSE PK	T3	PA QL(112 CAPS/28 DAYS) SP HD CSL
COMETRIQ 60 MG DAILY-DOSE PACK	T3	PA QL(84 CAPS/28 DAYS) SP HD CSL
COPIKTRA	T3	PA SP CSL
DANZITEN	T2	PA SP CSL
<i>dasatinib 100 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 140 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 20 mg tablet (Sprycel)</i>	T1	QL(3 TABS/DAY) SP HD CSL
<i>dasatinib 50 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
<i>dasatinib 70 mg tablet (Sprycel)</i>	T1	QL(2 TABS/DAY) SP HD CSL
<i>dasatinib 80 mg tablet (Sprycel)</i>	T1	QL(1 TAB/DAY) SP HD CSL
ENSACOVE 25 MG CAPSULE	T2	PA QL(9 CAPS/DAY) SP CSL
ENSACOVE 100 MG CAPSULE	T2	PA QL(2 CAPS/DAY) SP CSL
<i>erlotinib hcl</i>	T1	PA SP HD CSL
FOTIVDA	T3	PA QL(21 CAPS/28 DAYS) SP CSL
FRUZAQLA 1 MG CAPSULE	T2	PA QL(84 CAPS/28 DAYS) SP CSL
FRUZAQLA 5 MG CAPSULE	T2	PA QL(21 CAPS/28 DAYS) SP CSL
GAVRETO	T3	PA QL(4 CAPS/DAY) SP CSL
<i>gefitinib (Iressa)</i>	T1	PA SP HD CSL
GILOTRIF	T3	PA SP HD CSL
IBRANCE 100 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 100 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 125 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 125 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBRANCE 75 MG CAPSULE	T3	PA QL(21 CAPS/28 DAYS) SP HD CSL
IBRANCE 75 MG TABLET	T3	PA QL(21 TABS/28 DAYS) SP HD CSL
IBTROZI	T3	PA SP CSL
<i>imatinib mesylate 100 mg tab (Gleevec)</i>	T1	QL(6 TABS/DAY) SP HD CSL

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
<i>imatinib mesylate 400 mg tab</i> (Gleevec)	T1	QL(2 TABS/DAY) SP HD CSL
IMBRUVICA 140 MG CAPSULE	T2	PA QL(4 CAPS/DAY) SP CSL
IMBRUVICA 140 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 280 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 420 MG TABLET	T2	PA QL(1 TAB/DAY) SP CSL
IMBRUVICA 70 MG CAPSULE	T2	PA QL(1 CAP/DAY) SP CSL
IMBRUVICA 70 MG/ML SUSPENSION	T2	PA QL(8 MLS/DAY) SP CSL
IMKELDI	T2	PA SP CSL
INLYTA	T3	PA SP HD CSL
INREBIC	T3	PA SP HD CSL
IRESSA ( <i>gefitinib</i> )	T3	PA SP HD CSL
ITOVEBI	T3	PA SP HD CSL
IWILFIN	T3	PA QL(8 TABS/DAY) SP CSL
JAYPIRCA 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
JAYPIRCA 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
KISQALI 200 MG DAILY DOSE	T2	PA QL(21 TABS/28 DAYS) SP HD CSL
KISQALI 400 MG DAILY DOSE	T2	PA QL(42 TABS/28 DAYS) SP HD CSL
KISQALI 600 MG DAILY DOSE	T2	PA QL(63 TABS/28 DAYS) SP HD CSL
<i>lapatinib ditosylate</i> (Tykerb)	T1	PA QL(6 TABS/DAY) SP HD CSL
LAZCLUZE	T3	PA SP CSL
LENVIMA	T2	PA SP HD CSL
LORBRENA 25 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
LORBRENA 100 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD CSL
LYNPARZA	T2	PA QL(4 TABS/DAY) SP HD CSL
LYTGOBI 12 MG DOSE (3X 4MG TB)	T3	PA QL(3 TABS/DAY) SP CSL
LYTGOBI 16 MG DOSE (4X 4MG TB)	T3	PA QL(4 TABS/DAY) SP CSL
LYTGOBI 20 MG DOSE (5X 4MG TB)	T3	PA QL(5 TABS/DAY) SP CSL
NERLYNX	T3	PA SP HD CSL
<i>nilotinib hcl</i> (Tasigna)	T1	PA QL(4 CAPS/DAY) SP HD CSL
NINLARO	T3	PA QL(3 CAPS/28 DAYS) SP HD CSL
OGSIVEO 100 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
OGSIVEO 50 MG TABLET	T3	PA QL(6 TABS/DAY) SP CSL

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
OJJAARA	T3	PA QL(1 TAB/DAY) SP CSL
<i>pazopanib hcl 200 mg tablet (Votrient)</i>	T1	PA QL(4 TABS/DAY) SP CSL
PEMAZYRE	T3	PA QL(14 TABS/21 DAYS) SP CSL
PIQRAY	T2	PA SP CSL
QINLOCK	T3	PA QL(3 TABS/DAY) SP CSL
RETEVMO 40 MG CAPSULE	T3	PA QL(6 CAPS/DAY) SP HD CSL
RETEVMO 40 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD CSL
RETEVMO 80 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
RETEVMO 80 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 120 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
RETEVMO 160 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD CSL
REVUFORJ 25 MG TABLET	T3	PA QL(4 TABS/DAY) SP CSL
REVUFORJ 110 MG TABLET	T3	PA QL(2 TABS/DAY) SP CSL
REVUFORJ 160 MG TABLET	T3	PA QL(8 TABS/DAY) SP CSL
ROMVIMZA	T3	PA QL(8 CAPS/28 DAYS) SP CSL
ROZLYTREK	T3	PA SP HD CSL
RUBRACA	T2	PA QL(4 TABS/DAY) SP CSL
RYDAPT	T3	PA SP HD CSL
SCEMBLIX 20 MG TABLET	T2	PA QL(2 TABS/DAY) SP CSL
SCEMBLIX 40 MG TABLET	T2	PA SP CSL
SCEMBLIX 100 MG TABLET	T2	PA SP CSL
<i>sorafenib tosylate (Nexavar)</i>	T1	PA QL(4 TABS/DAY) SP HD CSL
STIVARGA	T2	PA QL(84 TABS/28 DAYS) SP HD CSL
<i>sunitinib malate (Sutent)</i>	T1	PA QL(1 CAP/DAY) SP HD CSL
TABRECTA	T3	PA QL(4 TABS/DAY) SP HD CSL
TAGRISSO	T3	PA SP HD CSL
TALZENNA 0.1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.25 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.35 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 0.5 MG CAPSULE	T3	PA SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-NEOPLASTICS (Cancer) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC SYSTEMIC ENZYME INHIBITORS (cont.)</b>		
TALZENNA 0.5 MG SOFTGEL	T3	PA SP CSL
TALZENNA 0.75 MG SOFTGEL	T3	PA SP CSL
TALZENNA 1 MG CAPSULE	T3	PA QL(1 CAP/DAY) SP CSL
TALZENNA 1 MG SOFTGEL	T3	PA QL(1 CAP/DAY) SP CSL
TEPMETKO	T3	PA QL(2 TABS/DAY) SP CSL
TRUQAP	T2	PA QL(64 TABS/28 DAYS) SP CSL
TUKYSA	T3	PA SP CSL
TURALIO	T3	PA QL(4 CAPS/DAY) SP CSL
VANFLYTA	T3	PA QL(2 TABS/DAY) SP CSL
VERZENIO	T2	PA QL(2 TABS/DAY) SP HD CSL
VITRAKVI	T3	PA SP HD CSL
VIZIMPRO	T3	PA SP HD CSL
VONJO	T3	PA QL(4 CAPS/DAY) SP CSL
XALKORI 150 MG PELLETT	T3	PA QL(6 PELLETS/DAY) SP HD CSL
XALKORI 20 MG PELLETT	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XALKORI 200 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 250 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP HD CSL
XALKORI 50 MG PELLETT	T3	PA QL(4 PELLETS/DAY) SP HD CSL
XOSPATA	T3	PA SP CSL
ZEJULA	T2	PA QL(1 TAB/DAY) SP CSL
ZYDELIG	T3	PA QL(2 TABS/DAY) SP HD CSL
<b>ANTI-NEOPLASTIC, ANTI-PROGRAMMED DEATH-I (PD-I) MAB</b>		
LIBTAYO	T2	PA SP
OPDIVO	T3	PA SP HD
<b>ANTI-NEOPLASTIC-B CELL LYMPHOMA-2(BCL-2) INHIBITORS</b>		
VENCLEXTA	T2	PA SP CSL
VENCLEXTA STARTING PACK	T2	PA SP CSL
<b>ANTINEOPLASTIC-ENZYME INHIB, ANTIANDROGEN COMB.</b>		
AKEEGA	T3	PA QL(2 TABS/DAY) SP CSL
<b>ANTINEOPLASTIC-HYPOXIA INDUCIBLE FACTOR (HIF) INH</b>		
WELIREG	T3	PA QL(3 TABS/DAY) SP CSL
<b>ANTINEOPLASTIC-IMMUNOTHERAPY CHECKPOINT INHIB COMB</b>		
OPDUALAG	T3	PA SP HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

ANTI-NEOPLASTICS (Cancer) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NEOPLASTIC-ISOCITRATE DEHYDROGENASE INHIBITORS</b>		
IDHIFA	T3	PA SP HD CSL
REZLIDHIA	T3	PA QL(2 CAPS/DAY) SP CSL
TIBSOVO	T3	PA SP CSL
VORANIGO	T3	PA SP CSL
<b>ANTI-NEOPLASTICS ANTIBODY/ANTIBODY-DRUG COMPLEXES</b>		
ENHERTU	T3	PA SP HD
TIVDAK	T3	PA SP HD
ZYNLONTA	T3	PA SP
<b>ANTI-NEOPLASTICS, MISCELLANEOUS</b>		
<i>etoposide</i>	T1	SP HD CSL
LYSODREN	T2	CSL
MATULANE	T2	SP CSL
<i>tretinoin 10 mg capsule</i>	T1	PA CSL
<b>ANTI-NEOPLASTIC-SELECT INHIB OF NUCLEAR EXP (SINE)</b>		
XPOVIO	T3	PA SP CSL
<b>CYTOTOXIC T-LYMPHOCYTE ANTIGEN (CTLA-4) RMC ANTIBODY</b>		
YERVOY	T3	PA SP HD
<b>IMMUNOMODULATORS</b>		
ACTIMMUNE	T2	PA SP HD
<b>SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)</b>		
FARESTON ( <i>toremifene citrate</i> )	T3	QL(2 TABS/DAY) HD CSL
ORSERDU 345 MG TABLET	T3	PA QL(1 TAB/DAY) SP CSL
ORSERDU 86 MG TABLET	T3	PA QL(3 TABS/DAY) SP CSL
SOLTAMOX	T2	HD CSL
<i>tamoxifen citrate</i>	T1	HD PPACA CSL
<i>toremifene citrate</i> (Fareston)	T1	QL(2 TABS/DAY) HD CSL
<b>STEROID ANTI-NEOPLASTICS</b>		
<i>megestrol 20 mg tablet</i>	T1	CSL
<i>megestrol 40 mg tablet</i>	T1	CSL
<b>ANTI-NEOPLASTICS (Skin Conditions)</b>		
<b>PHOTOACT, TOPICAL ANTI-NEOPLAST, PREMALIGNANT LESIONS</b>		
LEVULAN	T3	SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-NEOPLASTICS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-NEOPLASTIC PREMALIGNANT LESION AGENTS</b>		
EFUDEX ( <i>fluorouracil</i> )	T3	
FLUOROPLEX	T2	
<i>fluorouracil</i>	T1	
FLUOROURACIL	T1	
<i>fluorouracil</i> (Efudex)	T1	
PANRETIN	T3	SP HD
VALCHLOR	T3	SP HD

### ANTI-OBESITY DRUGS (Weight Management)

<b>ANTI-OBESITY - ANOREXIC AGENTS</b>		
<i>benzphetamine hcl</i>	T1	
<i>diethylpropion hcl</i>	T1	
LOMAIRA	T3	PA
<i>phendimetrazine tartrate</i>	T1	
<i>phentermine 15 mg capsule</i>	T1	
<i>phentermine 30 mg capsule</i>	T1	
<i>phentermine 37.5 mg capsule</i>	T1	
<i>phentermine 37.5 mg tablet</i>	T1	
<i>phentermine 8 mg tablet</i>	T1	PA
<i>phentermine/topiramate</i> (Qsymia)	T1	
QSYMIA ( <i>phentermine/topiramate</i> )	T3	PA
<b>ANTI-OBESITY - INCRETIN MIMETICS COMBINATION</b>		
ZEPBOUND 2.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/365 DAYS)
ZEPBOUND 5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 7.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 10 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 12.5 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
ZEPBOUND 15 MG/0.5 ML PEN	T2	PA QL(2 MLS/30 DAYS)
<b>ANTI-OBESITY - MELANOCORTIN 4 RECEPTOR AGONISTS</b>		
IMCIVREE	T3	PA QL(9 MLS/30 DAYS) SP
<b>ANTI-OBESITY GLUCAGON-LIKE PEPTIDE-I RECEPTOR AGONIST</b>		
<i>liraglutide 18 mg/3 ml pen</i> (Saxenda)	T1	PA
<i>liraglutide 5-pak 18 mg/3 ml</i> (Saxenda)	T1	PA
SAXENDA ( <i>liraglutide</i> )	T3	PA
WEGOVY	T2	PA QL(4 PENS/28 DAYS)

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-OBESITY DRUGS (Weight Management) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-OBESITY SEROTONIN 2C RECEPTOR AGONISTS</b>		
BELVIQ	T3	PA
BELVIQ XR	T3	PA
<b>ANTI-OBESITY - OPIOID ANTAG-NOREPI, DOPAMINE RU INHIB</b>		
CONTRAVE	T3	PA
<b>FAT ABSORPTION DECREASING AGENTS</b>		
XENICAL	T3	PA

### ANTI-PARASITICS (Eye Conditions)

<b>OPHTHALMIC (EYE) ANTIPARASITICS</b>		
XDEMZY	T2	PA QL(10 MLS/56 DAYS) SP

### ANTI-PARASITICS (Infections)

<b>ANTI-PARASITICS</b>		
ALINIA 100 MG/5 ML SUSPENSION	T3	
<i>nitazoxanide</i> (Alinia)	T1	
<b>TOPICAL ANTI-PARASITICS</b>		
<i>crotamiton</i>	T1	
ELIMITE ( <i>permethrin</i> )	T3	
EURAX	T3	
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	
<i>permethrin</i> (Elimite)	T1	
<i>spinosad</i> (Natroba)	T1	
ULESFIA	T3	
<i>lindane</i>	T1	
<i>malathion</i> (Ovide)	T1	
OVIDE ( <i>malathion</i> )	T3	

### ANTI-PARKINSON DRUGS (Parkinson's Disease)

<b>ANTI-PARKINSONISM DRUGS, ANTI-CHOLINERGIC</b>		
<i>benztropine mesylate</i>	T1	HD
<i>trihexyphenidyl hcl</i>	T1	HD

T1 – Typically Generics

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
<i>amantadine hcl</i>	T1	HD
APOKYN	T2	PA SP HD
<i>apomorphine hcl</i>	T1	HD
<i>bromocriptine mesylate</i>	T1	HD
<i>carbidopa/levodopa</i>	T1	HD
<i>carbidopa/levodopa (Sinemet)</i>	T1	HD
<i>carbidopa/levodopa/entacapone</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 100)</i>	T1	HD
<i>carbidopa/levodopa/entacapone (Stalevo 75)</i>	T1	HD
<i>carbidopa-levo er 25-100 tab</i>	T1	HD
<i>carbidopa-levo er 50-200 tab</i>	T1	HD
CREXONT	T3	ST HD
DUOPA	T3	SP HD
<i>entacapone</i>	T1	HD
INBRIJA	T3	PA SP HD
NEUPRO	T3	HD
NOURIANZ	T3	PA QL(1 TAB/DAY) SP HD
<i>pramipexole di-hcl</i>	T1	HD
<i>pramipexole er 0.375 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 0.75 mg tablet</i>	T1	HD
<i>pramipexole er 1.5 mg tablet (Mirapex Er)</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 2.25 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>pramipexole er 3 mg tablet</i>	T1	HD
<i>pramipexole er 3.75 mg tablet</i>	T1	HD
<i>pramipexole er 4.5 mg tablet</i>	T1	HD
<i>rasagiline mesylate 0.5 mg tab (Azilect)</i>	T1	QL(1 TAB/DAY) HD
<i>rasagiline mesylate 1 mg tab (Azilect)</i>	T1	HD
<b>ANTI-PARKINSONISM DRUGS, OTHER</b>		
<i>ropinirole hcl</i>	T1	HD
RYTARY	T3	ST HD

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTI-PARKINSON DRUGS (Parkinson's Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PARKINSONISM DRUGS, OTHER (cont.)</b>		
<i>selegiline hcl</i>	T1	HD
SINEMET ( <i>carbidopa/levodopa</i> )	T3	HD
STALEVO 75 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
STALEVO 100 ( <i>carbidopa-levodopa-entacapone</i> )	T3	HD
TASMAR ( <i>tolcapone</i> )	T3	HD
<i>tolcapone</i> (Tasmar)	T1	HD
XADAGO	T3	ST HD
<b>DECARBOXYLASE INHIBITORS</b>		
<i>carbidopa</i> (Lodosyn)	T1	
<b>ANTI-PLATELET DRUGS (Blood Thinners/Anti-Clotting)</b>		
<b>PLATELET AGGREGATION INHIBITORS</b>		
<i>aspirin/dipyridamole</i>	T1	HD
ASPIRIN-OMEPRAZOLE DR 81-40 MG	T1	HD
<i>cilostazol</i>	T1	HD
<i>clopidogrel bisulfate</i>	T1	HD
<i>clopidogrel bisulfate</i> (Plavix)	T1	HD
<i>dipyridamole</i>	T1	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticagrelor</i> (Brilinta)	T1	HD
ZONTIVITY	T1	HD
<b>PLATELET AGGREGATION INHIBITORS</b>		
EFFIENT ( <i>prasugrel hcl</i> )	T3	HD
<i>prasugrel hcl</i> (Effient)	T1	HD
<i>ticagrelor</i>	T1	HD
<i>ticlopidine hcl</i>	T1	HD
<b>PLATELET REDUCING AGENTS</b>		
AGRYLIN ( <i>anagrelide hcl</i> )	T3	
<i>anagrelide hcl</i>	T1	
<i>anagrelide hcl</i> (Agrylin)	T1	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

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HD – May require home delivery pharmacy

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# List of Prescription Medications

ANTIVIRALS (AIDS/HIV)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-RETROVIRAL - CAPSID INHIBITORS</b>		
SUNLENCA 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 4- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
SUNLENCA 463.5 MG/1.5 ML VIAL	T3	PA SP
SUNLENCA 5- 300 MG TABLET	T3	PA QL(5 TABS/180 DAYS) SP
<b>ANTIRETROVIRAL - CAPSID INHIBITORS (PREP)</b>		
YEZTUGO 463.5 MG/1.5 ML VIAL	T2	SP PPACA
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMB.</b>		
CABENUVA	T3	PA SP
JULUCA	T2	QL(1 TAB/DAY) SP
<b>ANTI-RETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMB.</b>		
DOVATO	T2	QL(1 TAB/DAY) SP
<b>ANTI-RETROVIRAL - NRTIS AND INTEGRASE INHIBITORS COMB</b>		
TRIUMEQ	T2	QL(1 TAB/DAY) SP
TRIUMEQ PD	T2	QL(6 TABS/DAY) SP
<b>ANTI-RETROVIRAL - NUCLEOSIDE, NUCLEOTIDE, PROTEASE INH.</b>		
SYMTOZA	T2	QL(1 TAB/DAY) SP
<b>ANTIVIRALS - HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB</b>		
APTIVUS	T2	PA SP
<i>darunavir</i> (Prezista)	T1	SP
PREZCOBIX	T3	PA SP
PREZISTA 100 MG/ML SUSPENSION	T2	SP
PREZISTA 150 MG TABLET	T2	SP
PREZISTA 75 MG TABLET	T2	SP
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG</b>		
CIMDUO	T3	PA SP
DESCOVY 120-15 MG TABLET	T2	SP
DESCOVY 200-25 MG TABLET	T2	SP PPACA
<i>emtricitabine-tenofv 100-150mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 133-200mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 167-250mg</i> (Truvada)	T1	SP
<i>emtricitabine-tenofv 200-300mg</i> (Truvada)	T1	SP PPACA
<b>ANTIVIRALS - HIV-SPEC, NUCLEOSIDE ANALOG, RTI COMB</b>		
<i>abacavir sulfate/lamivudine</i> (Epzicom)	T1	PA SP
<i>lamivudine/zidovudine</i> (Combivir)	T1	SP

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, CCR5 CO-RECEPTOR ANTAG.</b>		
<i>maraviroc</i> (Selzentry)	T1	PA SP
SELZENTRY 20 MG/ML ORAL SOLN	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, CD4 ATTACHMENT INHIBITOR</b>		
RUKOBIA	T3	PA QL(2 TABS/DAY) SP
<b>ANTIVIRALS - HIV-SPECIFIC, FUSION INHIBITORS</b>		
FUZEON	T2	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NON-NUCLEOSIDE, RTI</b>		
FUZEON	T2	PA SP
EDURANT	T3	PA SP
EDURANT PED	T3	PA SP
<i>efavirenz</i>	T1	PA SP
<i>etravirine</i> (Intelence)	T1	SP
INTELENCE 25 MG TABLET	T3	PA SP
<i>nevirapine</i>	T1	PA SP
PIFELTRO	T3	PA SP
<b>ANTIVIRALS - HIV-SPECIFIC, NUCLEOSIDE ANALOG, RTI</b>		
<i>abacavir sulfate</i>	T1	PA SP
<i>abacavir sulfate</i> (Ziagen)	T1	PA SP
<i>emtricitabine</i> (Emtriva)	T1	SP
EMTRIVA 10 MG/ML SOLUTION	T2	PA SP
<i>lamivudine 10 mg/ml oral soln</i> (EpiVir)	T1	SP
<i>lamivudine 150 mg tablet</i> (EpiVir)	T1	SP
<i>lamivudine 300 mg tablet</i> (EpiVir)	T1	PA SP
<i>lamivudine 300 mg/30ml sol cup</i> (EpiVir)	T1	SP
<i>zidovudine</i>	T1	SP
<i>zidovudine</i> (Retrovir)	T1	SP
<i>tenofovir disoproxil fumarate</i> (Viread)	T1	PA SP
VIREAD 150 MG TABLET	T2	PA SP
VIREAD 200 MG TABLET	T2	PA SP
VIREAD 250 MG TABLET	T2	PA SP
VIREAD POWDER	T2	PA SP

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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## List of Prescription Medications

### ANTIVIRALS (AIDS/HIV) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITOR COMB</b>		
lopinavir/ritonavir	T1	SP
<i>lopinavir/ritonavir (Kaletra)</i>	T1	SP
<b>ANTIVIRALS - HIV-SPECIFIC, PROTEASE INHIBITORS</b>		
<i>atazanavir sulfate</i>	T1	PA SP
<i>atazanavir sulfate (Reyataz)</i>	T1	PA SP
EVOTAZ	T3	PA SP
<i>fosamprenavir calcium</i>	T1	PA SP
NORVIR 100 MG POWDER PACKET	T2	SP
REYATAZ 50 MG POWDER PACKET	T2	PA SP
<i>ritonavir (Norvir)</i>	T1	SP
<b>ANTIVIRALS - HIV-1 INTEGRASE STRAND TRANSFER INHIBTR</b>		
APRETUDE	T2	SP PPACA
ISENTRESS	T2	SP
ISENTRESS HD	T2	PA SP
TIVICAY	T2	SP
TIVICAY PD	T2	SP
<b>ARTV NUCLEOSIDE, NUCLEOTIDE, NON-NUCLEOSIDE RTI COMB</b>		
DELSTRIGO	T3	PA QL(1 TAB/DAY) SP
<i>efavirenz/emtricit/tenofovr df</i>	T1	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofov disop (Symfi Lo)</i>	T1	QL(1 TAB/DAY) SP
<i>efavirenz/lamivu/tenofov disop (Symfi)</i>	T1	QL(1 TAB/DAY) SP
<i>emtricit/rilpivirine/tenof df (Complera)</i>	T1	QL(1 TAB/DAY) SP
ODEFSEY	T3	PA QL(1 TAB/DAY) SP
<b>ARV-NUCLEOSIDE, NUCLEOTIDE RTI, INTEGRASE INHIBITORS</b>		
BIKTARVY	T2	QL(1 TAB/DAY) SP
GENVOYA	T2	QL(1 TAB/DAY) SP
STRIBILD	T3	PA QL(1 TAB/DAY) SP
<b>ANTIVIRALS (Eye Conditions)</b>		
<b>EYE ANTIVIRALS</b>		
<i>trifluridine</i>	T1	
ZIRGAN	T3	

T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

PPACA – No Cost-Share Preventive Medication

CSL – Oral cancer medication subject to cost-share limits

# List of Prescription Medications

ANTIVIRALS (Infections)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRAL - MAIN PROTEASE (MPRO) INHIBITOR</b>		
PAXLOVID	T2	QL(1 TAB/120 DAYS)
<b>ANTIVIRAL - RNA POLYMERASE INHIBITOR</b>		
LAGEVRIO (EUA)	T2	QL(1 PACK/120 DAYS)
<b>ANTIVIRAL MONOCLONAL ANTIBODIES</b>		
BEYFORTUS	T3	PPACA
<b>ANTIVIRALS, GENERAL</b>		
<i>acyclovir 200 mg capsule</i>	T1	
<i>acyclovir 200 mg/5 ml susp</i>	T1	
<i>acyclovir 200 mg/5 ml susp cup</i>	T1	
<i>acyclovir 400 mg tablet</i>	T1	
<i>acyclovir 800 mg tablet</i>	T1	
<i>acyclovir 800 mg/20ml susp cup</i>	T1	
<i>famciclovir</i>	T1	
FLUMADINE ( <i>rimantadine hcl</i> )	T3	
LIVTENCITY	T3	PA QL(4 TABS/DAY) SP
<i>oseltamivir 6 mg/ml suspension (Tamiflu)</i>	T1	QL(180 MLS/30 DAYS)
<i>oseltamivir phos 30 mg capsule (Tamiflu)</i>	T1	QL(20 CAPS/30 DAYS)
<i>oseltamivir phos 45 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)
<i>oseltamivir phos 75 mg capsule (Tamiflu)</i>	T1	QL(10 CAPS/30 DAYS)
PREVMIS 120 MG PELLETT PACKET	T3	SP
PREVMIS 20 MG PELLETT PACKET	T3	SP
PREVMIS 240 MG TABLET	T3	SP HD
PREVMIS 480 MG TABLET	T3	SP HD
RELENZA	T3	QL(20 BLISTERS/30 DAYS)
<i>rimantadine hcl (Flumadine)</i>	T1	
TAMIFLU 30 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL(20 CAPS/30 DAYS)
TAMIFLU 45 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL(10 CAPS/30 DAYS)
TAMIFLU 6 MG/ML SUSPENSION ( <i>oseltamivir phosphate</i> )	T3	QL(180 MLS/30 DAYS)
TAMIFLU 75 MG CAPSULE ( <i>oseltamivir phosphate</i> )	T3	QL(10 CAPS/30 DAYS)
TEMBEXA	T3	
<i>valacyclovir hcl (Valtrex)</i>	T1	

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### ANTIVIRALS (Infections) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIVIRALS, GENERAL (cont.)</b>		
<i>valganciclovir hcl</i> (Valcyte)	T1	
VALTREX ( <i>valacyclovir hcl</i> )	T3	
XOFLUZA	T3	QL(2 TABS/30 DAYS)
<b>HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO</b>		
VOSEVI	T2	PA QL(1 TAB/DAY) SP HD
<b>HEP C VIRUS-NS5B POLYMERASE AND NS5A INHIB. COMBO.</b>		
EPCLUSA 150-37.5 MG PELLETT PKT	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 200 MG-50 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
EPCLUSA 200-50 MG PELLETT PACK	T2	PA QL(1 PACK/DAY) SP HD
EPCLUSA 400 MG-100 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 33.75-150 MG PELLETT PK	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG PELLETT PACKT	T2	PA QL(1 PACK/DAY) SP HD
HARVONI 45-200 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
HARVONI 90-400 MG TABLET	T2	PA QL(1 TAB/DAY) SP HD
<b>HEPATITIS B TREATMENT AGENTS</b>		
<i>adefovir dipivoxil</i>	T1	SP HD
BARACLUDE 0.05 MG/ML SOLUTION	T2	SP HD
<i>entecavir 0.5 mg tablet</i> (Baraclude)	T1	QL(1 TAB/DAY) SP HD
<i>entecavir 1 mg tablet</i> (Baraclude)	T1	SP HD
<i>lamivudine</i>	T1	SP
VEMLIDY	T2	SP HD
<b>HEPATITIS C TREATMENT AGENTS</b>		
PEGASYS	T2	PA SP HD
<i>ribavirin</i>	T1	SP HD
<b>HEPATITIS C VIRUS- NS5A AND NS3/4A INHIBITOR COMB</b>		
ZEPATIER	T2	PA QL(1 TAB/DAY) SP HD
<b>ANTIVIRALS (Skin Conditions)</b>		
<b>TOPICAL GENITAL WART-HPV TREATMENT AGENTS</b>		
VEREGEN	T3	
<b>AUTONOMIC DRUGS (Allergy/Nasal Sprays)</b>		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.15 mg auto-inject</i> (Epipen Jr)	T1	QL(4 UNITS/30 DAYS)

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### AUTONOMIC DRUGS (Allergy/Nasal Sprays) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANAPHYLAXIS THERAPY AGENTS (cont.)</b>		
<i>epinephrine 0.3 mg auto-inject</i> (Epipen 2-Pak)	T1	QL(4 UNITS/30 DAYS)
<i>epinephrine 0.3 mg auto-inject</i> (Epipen)	T1	QL(4 UNITS/30 DAYS)

### AUTONOMIC DRUGS (Alzheimer's Disease)

#### CHOLINESTERASE INHIBITORS

ARICEPT	T2	PA QL(4 PATCHES/28 DAYS) HD
<i>donepezil hcl</i>	T1	HD
<i>donepezil hcl</i> (Aricept)	T1	HD
EXELON ( <i>rivastigmine</i> )	T3	HD
<i>galantamine er 16 mg capsule</i>	T1	HD
<i>galantamine er 24 mg capsule</i>	T1	HD
<i>galantamine er 8 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>galantamine hbr</i>	T1	HD
<i>pyridostigmine 60 mg/5 ml cup</i> (Mestinon)	T1	HD
<i>pyridostigmine 60 mg/5 ml soln</i> (Mestinon)	T1	HD
<i>pyridostigmine br 60 mg tablet</i> (Mestinon)	T1	HD
<i>pyridostigmine bromide</i> (Mestinon)	T1	HD
<i>rivastigmine</i> (Exelon)	T1	HD
<i>rivastigmine tartrate</i>	T1	HD

### AUTONOMIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>10</sup>

#### ADRENERGICS, AROMATIC, NON-CATECHOLAMINE

<i>amphetamine sulfate</i> (Evekeo)	T1	PA
<i>dextroamphetamine er 10 mg cap</i> (Dexedrine)	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine er 15 mg cap</i> (Dexedrine)	T1	PA QL(3 CAPS/DAY)
<i>dextroamphetamine er 5 mg cap</i>	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine sulfate</i>	T1	PA
<i>dextroamphetamine sulfate</i> (Zenzedi)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Adderall Xr)	T1	PA QL(1 CAP/DAY)
<i>dextroamphetamine/amphetamine</i> (Adderall)	T1	PA
<i>dextroamphetamine/amphetamine</i> (Mydayis)	T1	PA QL(1 CAP/DAY)
<i>methamphetamine hcl</i> (Desoxyn)	T1	PA
XELSTRYM	T3	PA QL(1 PATCH/DAY)
ZENZEDI	T3	PA ST
ZENZEDI ( <i>dextroamphetamine sulfate</i> )	T3	PA ST

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### AUTONOMIC DRUGS (Blood Pressure/Heart Medications)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGIC VASOPRESSOR AGENTS</b>		
<i>droxidopa 100 mg capsule (Northera)</i>	T1	SP HD
<i>droxidopa 200 mg capsule (Northera)</i>	T1	SP HD
<i>droxidopa 300 mg capsule (Northera)</i>	T1	SP HD
<i>midodrine hcl</i>	T1	
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
DIBENZYLIN (phenoxybenzamine hcl)	T3	HD
<i>phenoxybenzamine hcl (Dibenzylin)</i>	T1	HD

### AUTONOMIC DRUGS (Urinary Tract Conditions)

<b>PARASYMPATHETIC AGENTS</b>		
<i>bethanechol chloride</i>	T1	HD
<i>cevimeline hcl (Evoxac)</i>	T1	HD
<i>pilocarpine hcl 5 mg tablet (Salagen)</i>	T1	HD
<i>pilocarpine hcl 7.5 mg tablet (Salagen)</i>	T1	HD
SALAGEN ( <i>pilocarpine hcl</i> )	T3	HD

### BIOLOGICALS (Allergy/Nasal Sprays)

<b>ALLERGENIC EXTRACTS, THERAPEUTIC</b>		
GRASTEK	T3	PA QL(1 TAB/DAY)
ODACTRA	T3	PA QL(1 TAB/DAY)
ORALAIR	T3	PA QL(1 TAB/DAY)
RAGWITEK	T3	PA QL(1 TAB/DAY)

### BIOLOGICALS (Blood Pressure/Heart Medications)

<b>PLASMA KALLIKREIN INHIBITORS</b>		
TAKHZYRO	T3	PA SP HD

### BIOLOGICALS (Miscellaneous)

<b>PKU TREATMENT AGENTS - PHENYLALANINE AMMONIA LYASE</b>		
PALYNZIQ	T3	PA SP HD

### BIOLOGICALS (Vaccines)

<b>COVID-19 VACCINES</b>		
COMIRNATY	T2	PPACA
COMIRNATY 2023-2024	T2	PPACA

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>COVID-19 VACCINES (cont.)</b>		
COMIRNATY 2024-2025	T2	PPACA
COMIRNATY 2025-2026 (12Y UP)	T2	PPACA
COMIRNATY 2025-2026(5-11Y)	T2	PPACA
JANSSEN COVID-19 VACCINE (EUA)	T2	PPACA
MNEXSPIKE 2025-2026 (12Y UP)	T2	PPACA
MODERNA COVID (12Y UP)VAC(EUA)	T2	PPACA
MODERNA COVID 23-24(6M-11Y)EUA	T2	PPACA
MODERNA COVID 24-25(6M-11Y)EUA	T2	PPACA
MODERNA COVID BIVAL(6MO UP)EUA	T2	PPACA
MODERNA COVID BIVAL(6MO-5Y)EUA	T2	PPACA
MODERNA COVID(6M-5Y) VACC(EUA)	T2	PPACA
MODERNA COVID-19 BOOSTER (EUA)	T2	PPACA
NOVAVAX COVID 2023-2024 (EUA)	T2	PPACA
NOVAVAX COVID 2024-2025 (EUA)	T2	PPACA
NOVAVAX COVID-19 VACC,ADJ(EUA)	T2	PPACA
NUVAXOVID 2025-2026	T2	PPACA
PFIZER COVID (12Y UP) VAC(EUA)	T2	PPACA
PFIZER COVID (5-11Y) VAC (EUA)	T2	PPACA
PFIZER COVID (6M-4Y) VACC(EUA)	T2	PPACA
PFIZER COVID 2023-24(5-11Y)EUA	T2	PPACA
PFIZER COVID 2023-24(6M-4Y)EUA	T2	PPACA
PFIZER COVID 2024-25(5-11Y)EUA	T2	PPACA
PFIZER COVID 2024-25(6M-4Y)EUA	T2	PPACA
PFIZER COVID BIVAL (12Y UP)EUA	T2	PPACA
PFIZER COVID BIVAL (5-11YR)EUA	T2	PPACA
PFIZER COVID BIVAL (6MO-4Y)EUA	T2	PPACA
PFIZER COVID-19 VACCINE (EUA)	T2	PPACA
SPIKEVAX 2023-2024	T2	PPACA
SPIKEVAX 2024-2025	T2	PPACA
SPIKEVAX 2025-2026 (12Y UP)	T2	PPACA
SPIKEVAX 2025-2026 (6M-11Y)	T2	PPACA
SPIKEVAX COVID (18Y UP) VACC	T2	PPACA

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENTERIC VIRUS VACCINES</b>		
IPOL	T2	PPACA
ROTARIX	T3	PPACA
ROTATEQ	T3	PPACA
<b>GRAM NEGATIVE COCCI VACCINES</b>		
BEXSERO	T2	PPACA
MENACTRA	T2	
MENVEO A-C-Y-W-135-DIP	T2	PPACA
PENBRAYA	T2	PPACA
PENMENVY MEN A-B-C-W-Y	T2	PPACA
TRUMENBA	T2	PPACA
<b>GRAM POSITIVE COCCI VACCINES</b>		
CAPVAXIVE	T2	PPACA
PNEUMOVAX 23	T2	PPACA
PREVNAR 13	T2	
PREVNAR 20	T2	PPACA
VAXNEUVANCE	T2	PPACA
<b>INFLUENZA VIRUS VACCINES</b>		
AFLURIA 2025-2026	T2	
AFLURIA 2025-2026 (3YR UP)	T2	PPACA
AFLURIA QUAD 2022-2023	T2	PPACA
AFLURIA QUAD 2022-23 (3YR UP)	T2	PPACA
AFLURIA QUAD 2023-2024	T2	PPACA
AFLURIA QUAD 2023-24 (3YR UP)	T2	PPACA
AFLURIA TRIV 2024-25 (3YR UP)	T2	PPACA
AFLURIA TRIVALENT 2024-25	T2	PPACA
FLUAD 2025-2026	T2	PPACA
FLUAD QUAD 2022-2023	T2	PPACA
FLUAD QUAD 2023-2024	T2	PPACA
FLUAD TRIVALENT 2024-2025	T2	PPACA
FLUARIX 2025-2026	T2	PPACA
FLUARIX QUAD 2022-2023	T2	PPACA

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ST – Step Therapy

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HD – May require home delivery pharmacy

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# List of Prescription Medications

## BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INFLUENZA VIRUS VACCINES (cont.)</b>		
FLUARIX QUAD 2023-2024	T2	PPACA
FLUARIX TRIVALENT 2024-2025	T2	PPACA
FLUBLOK 2025-2026	T2	PPACA
FLUBLOK QUAD 2022-2023	T2	PPACA
FLUBLOK QUAD 2023-2024	T2	PPACA
FLUBLOK TRIVALENT 2024-2025	T2	PPACA
FLUCELVAX 2025-2026 SYRINGE	T2	PPACA
FLUCELVAX 2025-2026 VIAL	T2	
FLUCELVAX QUAD 2022-2023	T2	PPACA
FLUCELVAX QUAD 2023-2024	T2	PPACA
FLUCELVAX TRIVALENT 2024-2025	T2	PPACA
FLULAVAL 2025-2026	T2	PPACA
FLULAVAL QUAD 2022-2023	T2	PPACA
FLULAVAL QUAD 2023-2024	T2	PPACA
FLULAVAL TRIVALENT 2024-2025	T2	PPACA
FLUMIST 2025-2026	T2	PPACA
FLUMIST HOME 2025-2026	T2	PPACA
FLUMIST QUAD 2022-2023	T2	PPACA
FLUMIST QUAD 2023-2024	T2	PPACA
FLUMIST TRIVALENT 2024-2025	T2	PPACA
FLUZONE 2025-2026 SYRINGE	T2	PPACA
FLUZONE 2025-2026 VIAL	T2	
FLUZONE HIGH-DOSE 2025-2026	T2	PPACA
FLUZONE HIGH-DOSE QUAD 2022-23	T2	PPACA
FLUZONE HIGH-DOSE QUAD 2023-24	T2	PPACA
FLUZONE HIGH-DOSE TRIV 2024-25	T2	PPACA
FLUZONE QUAD 2022-2023	T2	PPACA
FLUZONE QUAD 2023-2024	T2	PPACA
FLUZONE TRIVALENT 2024-2025	T2	PPACA
<b>NEUROTOXIC VIRUS VACCINES</b>		
DENGVAXIA	T2	PPACA
<b>TOXIN-PRODUCING BACILLI VACCINES/TOXOIDS</b>		
BCG VACCINE (TICE STRAIN)	T2	SP

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## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VACCINE/TOXOID PREPARATIONS, COMBINATIONS</b>		
ACTHIB	T2	PPACA
ADACEL TDAP	T2	PPACA
BOOSTRIX TDAP	T2	PPACA
DAPTACEL DTAP	T2	PPACA
DIPHtheria-TETANUS TOXOIDS-PED	T2	
HIBERIX	T2	PPACA
INFANRIX DTAP	T2	PPACA
KINRIX	T2	PPACA
M-M-R II VACCINE	T2	PPACA
PEDVAXHIB	T2	PPACA
PENTACEL	T2	PPACA
PENTACEL ACTHIB COMPONENT	T2	PPACA
PRIORIX	T2	PPACA
PROQUAD	T2	PPACA
QUADRACEL DTAP-IPV	T2	PPACA
TDVAX	T2	PPACA
TENIVAC	T2	PPACA
VAXELIS	T2	PPACA
<b>VIRAL/TUMORIGENIC VACCINES</b>		
ABRYSVO	T3	PPACA
ACAM2000 (NATIONAL STOCKPILE)	T3	
AREXVY	T3	PPACA
ENGERIX-B ADULT	T2	PPACA
ENGERIX-B PEDIATRIC-ADOLESCENT	T2	PPACA
ERVEBO (NATIONAL STOCKPILE)	T3	
GARDASIL 9	T2	PPACA
HEPLISAV-B	T2	PPACA
JYNNEOS	T3	
JYNNEOS (NATIONAL STOCKPILE)	T3	
MRESVIA	T3	PPACA
PEDIARIX	T2	PPACA
PREHEVBRIO	T2	PPACA

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## List of Prescription Medications

### BIOLOGICALS (Vaccines) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VIRAL/TUMORIGENIC VACCINES (cont.)</b>		
RECOMBIVAX HB	T2	PPACA
SHINGRIX	T2	QL(2 KITS/720 DAYS) PPACA
TWINRIX	T2	PPACA
VARIVAX VACCINE	T2	PPACA

### BLOOD (Blood Modifiers/Bleeding Disorders)

<b>AGENTS TO TX THROMBOTIC THROMBOCYTOPENIC PURPURA</b>		
CABLIVI	T3	PA SP
<b>ANTI-FIBRINOLYTIC AGENTS</b>		
AMICAR ( <i>aminocaproic acid</i> )	T3	SP HD
<i>aminocaproic acid</i> (Amicar)	T1	SP HD
<i>tranexamic acid</i> (Lysteda)	T1	SP
<b>ANTI-HEMOPHILIC FACTORS</b>		
ADVATE	T3	PA SP HD
ADYNOVATE	T2	PA SP HD
AFSTYLA	T2	PA SP HD
ALPHANATE	T3	PA SP HD
ALTUVIIO	T2	PA SP HD
ELOCTATE	T2	PA SP HD
ESPEROCT	T2	PA SP HD
HEMOFIL M	T3	PA SP HD
HUMATE-P	T3	PA SP HD
JIVI	T2	PA SP HD
KOATE	T3	PA SP HD
KOGENATE FS	T2	PA SP HD
KOVALTRY	T2	PA SP HD
NOVOEIGHT	T2	PA SP HD
NUWIQ	T3	PA SP HD
RECOMBINATE	T3	PA SP HD
WILATE	T3	PA SP HD
XYNTHA	T3	PA SP HD
XYNTHA SOLOFUSE	T3	PA SP HD

T1 – Typically Generics

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>COMPLEMENT INHIBITORS</b>		
EMPAVELI	T2	PA SP
FABHALTA	T2	PA QL(2 CAPS/DAY) SP
TAVNEOS	T3	PA QL(6 CAPS/DAY) SP
VOYDEYA	T2	PA QL(1 PACKET/28 Days) SP
<b>HEMOPHILIA TREATMENT AGENTS, NON-FACTOR REPLACEMENT</b>		
ALHEMO PEN	T2	PA SP
HEMLIBRA	T2	PA SP HD
HYMPAVZI PEN	T2	PA SP
<b>PYRUVATE KINASE ACTIVATORS</b>		
PYRUKYND 20 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 20-5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 5 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 5 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
PYRUKYND 50 MG TABLET	T3	PA QL(2 TABS/DAY) SP
PYRUKYND 50-20 MG TAPER PACK	T3	PA QL(2 PACKS/270 DAYS) SP
<b>SICKLE CELL ANEMIA AGENTS</b>		
DROXIA	T2	
SIKLOS	T3	PA
<b>TOPICAL HEMOSTATICS</b>		
ASTRINGYN	T3	
AVITENE	T3	
ENDO-AVITENE	T3	
EVICEL	T3	
<i>gelatin sponge, absorb/porcine (Gelfoam)</i>	T1	
GELFOAM	T3	
GELFOAM ( <i>gelatin sponge, absorb/porcine</i> )	T3	
GELFOAM COMPRESSED	T3	
MONSEL'S	T3	
RAPLIXA	T3	
RECOTHROM	T3	
SURGIFOAM	T1	
SYRINGE AVITENE	T3	
THROMBI-GEL	T3	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### BLOOD (Blood Modifiers/Bleeding Disorders) (cont.)

**Prescription Drug Name** **Drug Tier** **Coverage Requirements and Limits**

#### TOPICAL HEMOSTATICS (cont.)

THROMBIN-JMI	T3	
THROMBI-PAD	T3	
ULTRAFOAM	T3	

### BLOOD (Blood Thinners/Anti-Clotting)

#### HEMORRHEOLOGIC AGENTS

<i>pentoxifylline</i>	T1	HD
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### CARDIAC DRUGS (Blood Pressure/Heart Medications)

#### ANTI-ANGINAL, ANTI-ISCHEMIC AGENTS, NON-HEMODYNAMIC

<i>ranolazine</i>	T1	QL (4 TABS/DAY) HD
<i>ranolazine (Ranexa)</i>	T1	QL (4 TABS/DAY) HD

#### ANTI-ARRHYTHMICS

<i>amiodarone hcl</i>	T1	HD
<i>disopyramide phosphate (Norpace)</i>	T1	HD
<i>dofetilide 125 mcg capsule (Tikosyn)</i>	T1	QL(8 CAPS/DAY) HD
<i>dofetilide 250 mcg capsule (Tikosyn)</i>	T1	QL(4 CAPS/DAY) HD
<i>dofetilide 500 mcg capsule (Tikosyn)</i>	T1	QL(2 CAPS/DAY) HD
<i>flecainide acetate</i>	T1	HD
<i>mexiletine hcl</i>	T1	HD
MULTAQ	T2	HD
NORPACE ( <i>disopyramide phosphate</i> )	T3	PA HD
NORPACE CR	T3	HD
<i>pacerone 100 mg tablet</i>	T3	PA HD
<i>pacerone 200 mg tablet</i>	T1	HD
<i>pacerone 400 mg tablet</i>	T3	PA HD
<i>propafenone hcl</i>	T1	HD
<i>quinidine gluconate</i>	T1	HD
<i>quinidine sulfate</i>	T1	HD
RYTHMOL SR ( <i>propafenone hcl er</i> )	T3	PA HD
TIKOSYN 125 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (8 CAPS/DAY) HD
TIKOSYN 250 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (4 CAPS/DAY) HD
TIKOSYN 500 MCG CAPSULE ( <i>dofetilide</i> )	T3	PA QL (2 CAPS/DAY) HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS</b>		
<i>amlodipine besylate</i> (Norvasc)	T1	HD
CALAN SR ( <i>verapamil er</i> )	T3	HD
<i>diltiazem 24h er(la) 120 mg tb</i> (Cardizem La)	T1	QL(1 TAB/DAY) HD
<i>diltiazem 24h er(la) 180 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 240 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 300 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 360 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem 24h er(la) 420 mg tb</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i>	T1	HD
<i>diltiazem hcl</i> (Cardizem Cd)	T1	HD
<i>diltiazem hcl</i> (Cardizem La)	T1	HD
<i>diltiazem hcl</i> (Cardizem)	T1	HD
<i>diltiazem hcl</i> (Tiazac)	T1	HD
<i>felodipine</i>	T1	HD
<i>isradipine</i>	T1	
<i>nicardipine hcl</i>	T1	HD
<i>nifedipine</i>	T1	HD
<i>nifedipine</i> (Procardia XI)	T1	HD
<i>nimodipine 30 mg capsule</i>	T1	HD
<i>nimodipine 60 mg/20 ml soln</i>	T1	
<i>nisoldipine er 17 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>nisoldipine er 25.5 mg tablet</i>	T1	HD
<i>nisoldipine er 30 mg tablet</i>	T1	HD
<i>nisoldipine er 34 mg tablet</i> (Sular)	T1	HD
<i>nisoldipine er 40 mg tablet</i>	T1	HD
<i>nisoldipine er 8.5 mg tablet</i> (Sular)	T1	HD
NORLIQVA	T2	QL(1 TAB/DAY) HD
NYMALIZE	T3	
SULAR ( <i>nisoldipine</i> )	T3	HD
TIAZAC ( <i>diltiazem hcl</i> )	T3	HD
<i>verapamil hcl</i>	T1	HD

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CARDIAC DRUGS (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CALCIUM CHANNEL BLOCKING AGENTS (cont.)</b>		
<i>verapamil hcl</i> (Calan Sr)	T1	HD
<i>verapamil hcl</i> (Verelan Pm)	T1	HD
<i>verapamil hcl</i> (Verelan)	T1	HD
VERELAN ( <i>verapamil hcl</i> )	T3	HD
VERELAN PM ( <i>verapamil hcl</i> )	T3	HD
<b>CARDIAC MYOSIN INHIBITOR</b>		
CAMZYOS	T3	PA QL(1 CAP/DAY) SP HD
<b>DIGITALIS GLYCOSIDES</b>		
<i>digoxin</i> (Lanoxin)	T1	HD
<i>digoxin 0.05 mg/ml solution</i>	T1	HD
<i>digoxin 0.125 mg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 0.25 mg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 125 mcg tablet</i> (Lanoxin)	T1	HD
<i>digoxin 250 mcg tablet</i> (Lanoxin)	T1	HD
<b>HEART RATE REDUCING, SA SELECTIVE I(F) CURRENT INH.</b>		
CORLANOR 5 MG/5 ML ORAL SOLN	T2	PA SP HD
<i>ivabradine hcl</i> (Corlanor)	T1	PA HD
<b>VASODILATORS, CORONARY</b>		
<i>isosorbide dinitrate 10 mg tab</i>	T1	HD
<i>isosorbide dinitrate 20 mg tab</i>	T1	HD
<i>isosorbide dinitrate 30 mg tab</i>	T1	HD
<i>isosorbide dinitrate 5 mg tab</i> (Isordil Titradoso)	T1	HD
<i>isosorbide mononitrate</i>	T1	HD
NITRO-DUR	T3	HD
<i>nitroglycerin</i>	T1	HD
<i>nitroglycerin 0.3 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 0.4 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 0.6 mg tablet sl</i> (Nitrostat)	T1	HD
<i>nitroglycerin 400 mcg spray</i> (Nitrolingual)	T1	HD
NITROLINGUAL ( <i>nitroglycerin</i> )	T3	HD
NITROMIST ( <i>nitroglycerin</i> )	T3	HD
NITROSTAT ( <i>nitroglycerin</i> )	T3	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CARDIOVASCULAR (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PULM ANTI-HTN, SOLUBLE GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS	T2	PA SP HD
<b>PULM.ANTI-HTN, SEL.C-GMP PHOSPHODIESTERASE T5 INHIB</b>		
<i>sildenafil 10 mg/ml oral susp (Revatio)</i>	T1	PA SP HD
<i>sildenafil 20 mg tablet (Revatio)</i>	T1	PA SP HD
<i>tadalafil (Adcirca)</i>	T1	PA SP HD
<i>tadalafil 20 mg tablet (Adcirca)</i>	T1	PA SP HD
<b>PULMONARY ANTI-HTN, ENDOTHELIN RECEPTOR ANTAGONIST</b>		
<i>ambrisentan (Letairis)</i>	T1	PA SP HD
<i>bosentan (Tracleer)</i>	T1	PA SP HD
OPSUMIT	T2	PA SP HD
TRACLEER 125 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
TRACLEER 32 MG TABLET FOR SUSP ( <i>bosentan</i> )	T2	PA SP HD
TRACLEER 62.5 MG TABLET ( <i>bosentan</i> )	T3	PA SP HD
<b>PULMONARY ANTIHYPER AGENT, ACTRIIA-FC</b>		
WINREVAIR	T3	PA SP HD
WINREVAIR (2 PACK)	T3	PA SP HD
<b>PULMONARY ANTIHYPERTENSIVES, PROSTACYCLIN-TYPE</b>		
ORENITRAM ER	T3	PA SP HD
ORENITRAM MONTH 1 TITRATION KT	T3	PA QL(168 TABS/180 DAYS) SP HD
ORENITRAM MONTH 2 TITRATION KT	T3	PA QL(336 TABS/180 DAYS) SP HD
ORENITRAM MONTH 3 TITRATION KT	T3	PA QL(252 TABS/180 DAYS) SP HD
TYVASO	T3	PA SP HD
TYVASO DPI	T2	PA SP HD
TYVASO INSTITUTIONAL START KIT	T3	PA SP HD
TYVASO REFILL KIT	T3	PA SP HD
TYVASO STARTER KIT	T3	PA SP HD
UPTRAVI	T2	PA SP HD
VENTAVIS	T2	PA SP HD
<b>PULMONARY HTN-ENDOTHELIN RECEPT ANTG-CGMP PDE5 INH</b>		
OPSYNVI	T2	PA QL(1 TAB/DAY) SP HD

### CARDIOVASCULAR (Blood Pressure/Heart Medications)

<b>ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION</b>		
<i>amlodipine besylate/benazepril</i>	T1	HD
<i>amlodipine besylate/benazepril (Lotrel)</i>	T1	HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACE INHIBITOR-CALCIUM CHANNEL BLOCKER COMBINATION (cont.)</b>		
PRESTALIA 14 MG-10 MG TABLET	T3	HD
PRESTALIA 3.5 MG-2.5 MG TABLET	T3	QL (1 TAB/DAY) HD
PRESTALIA 7 MG-5 MG TABLET	T3	QL (1 TAB/DAY) HD
<i>trandolapril/verapamil hcl</i>	T1	HD
<b>ACE INHIBITOR-THIAZIDE OR THIAZIDE-LIKE DIURETIC</b>		
<i>benazepril/hydrochlorothiazide</i>	T1	HD
<i>benazepril/hydrochlorothiazide (Lotensin Hct)</i>	T1	HD
<i>captopril-hctz 25-15 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>captopril-hctz 25-25 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>captopril-hctz 50-15 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>captopril-hctz 50-25 mg tablet</i>	T1	QL(2 TABS/DAY) HD
<i>enalapril/hydrochlorothiazide</i>	T1	HD
<i>enalapril/hydrochlorothiazide (Vaseretic)</i>	T1	HD
<i>fosinopril/hydrochlorothiazide</i>	T1	HD
<i>lisinopril/hydrochlorothiazide (Zestoretic)</i>	T1	HD
<i>quinapril/hydrochlorothiazide (Accuretic)</i>	T1	HD
<b>ALPHA/BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>carvedilol (Coreg)</i>	T1	HD
<i>carvedilol er 10 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 20 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 40 mg capsule (Coreg Cr)</i>	T1	QL(1 CAP/DAY) HD
<i>carvedilol er 80 mg capsule (Coreg Cr)</i>	T1	HD
<i>labetalol hcl 100 mg tablet</i>	T1	HD
<i>labetalol hcl 200 mg tablet</i>	T1	HD
<i>labetalol hcl 300 mg tablet</i>	T1	HD
LABETALOL HCL 400 MG TABLET	T3	HD
<b>ALPHA-ADRENERGIC BLOCKING AGENTS</b>		
CARDURA XL	T3	HD
<i>doxazosin mesylate (Cardura)</i>	T1	HD
MINIPRESS	T3	HD
<i>prazosin hcl</i>	T1	HD
<i>prazosin hcl (Minipress)</i>	T1	HD
<i>terazosin hcl</i>	T1	HD

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANGIOTEN.RECEPTR ANTAG-CALCIUM CHANL BLKR-THIAZIDE</b>		
<i>amlodipine/valsartan/hcthiazyd</i> (Exforge Hct)	T1	HD
<i>olmesartan/amlodipin/hcthiazyd</i> (Tribenzor)	T1	HD
<b>ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB (ARNI)</b>		
ENTRESTO SPRINKLE	T2	HD
<i>sacubitril/valsartan</i> (Entresto)	T1	QL(2 TABS/DAY) HD
<b>ANGIOTENSIN RECEPTOR ANTAG.-THIAZIDE DIURETIC COMB</b>		
<i>candesartan/hydrochlorothiazid</i> (Atacand Hct)	T1	HD
<i>irbesartan/hydrochlorothiazide</i> (Avalide)	T1	HD
<i>losartan/hydrochlorothiazide</i> (Hyzaar)	T1	HD
<i>olmesartan-hctz 20-12.5 mg tab</i> (Benicar Hct)	T1	QL(1 TAB/DAY) HD
<i>olmesartan-hctz 40-12.5 mg tab</i> (Benicar Hct)	T1	HD
<i>olmesartan-hctz 40-25 mg tab</i> (Benicar Hct)	T1	HD
<i>telmisartan-hctz 40-12.5 mg tb</i> (Micardis Hct)	T1	QL(1 TAB/DAY) HD
<i>telmisartan-hctz 80-12.5 mg tb</i> (Micardis Hct)	T1	HD
<i>telmisartan-hctz 80-25 mg tab</i> (Micardis Hct)	T1	HD
<i>valsartan/hydrochlorothiazide</i> (Diovan Hct)	T1	HD
<b>ANGIOTENSIN RECEPTOR BLOCKR-CALCIUM CHANNEL BLOCKR</b>		
<i>amlodipine besylate/valsartan</i> (Exforge)	T1	HD
<i>amlodipine-olmesartan 10-20 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 10-40 mg</i> (Azor)	T1	HD
<i>amlodipine-olmesartan 5-20 mg</i> (Azor)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-olmesartan 5-40 mg</i> (Azor)	T1	HD
<i>telmisartan-amlodipine 40-10</i>	T1	HD
<i>telmisartan-amlodipine 40-5 mg</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan-amlodipine 80-10</i>	T1	HD
<i>telmisartan-amlodipine 80-5 mg</i>	T1	HD
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS</b>		
<i>benazepril hcl</i>	T1	HD
<i>benazepril hcl</i> (Lotensin)	T1	HD
<i>captopril</i>	T1	HD
<i>enalapril maleate</i> (Epaned)	T1	HD
<i>enalapril maleate</i> (Vasotec)	T1	HD
<i>fosinopril sodium</i>	T1	HD

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, ACE INHIBITORS (cont.)</b>		
<i>lisinopril (Zestril)</i>	T1	HD
<i>moexipril hcl</i>	T1	HD
<i>perindopril erbumine</i>	T1	HD
<i>quinapril hcl (Accupril)</i>	T1	HD
<i>ramipril</i>	T1	HD
<i>ramipril (Altace)</i>	T1	HD
<i>trandolapril</i>	T1	HD
<b>ANTI-HYPERTENSIVES, ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
<i>candesartan cilexetil (Atacand)</i>	T1	HD
<i>eprosartan mesylate</i>	T1	HD
<i>irbesartan</i>	T1	HD
<i>irbesartan (Avapro)</i>	T1	HD
<i>losartan potassium (Cozaar)</i>	T1	HD
<i>olmesartan medoxomil 20 mg tab (Benicar)</i>	T1	QL(1 TAB/DAY) HD
<i>olmesartan medoxomil 40 mg tab (Benicar)</i>	T1	HD
<i>olmesartan medoxomil 5 mg tab (Benicar)</i>	T1	HD
<i>telmisartan 20 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 40 mg tablet (Micardis)</i>	T1	QL(1 TAB/DAY) HD
<i>telmisartan 80 mg tablet (Micardis)</i>	T1	HD
<i>valsartan 160 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 20 mg/5 ml solution</i>	T1	HD
<i>valsartan 320 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 40 mg tablet (Diovan)</i>	T1	HD
<i>valsartan 80 mg tablet (Diovan)</i>	T1	HD
<b>ANTI-HYPERTENSIVES, GANGLIONIC BLOCKERS</b>		
VECAMYL	T1	
<b>ANTI-HYPERTENSIVES, MISCELLANEOUS</b>		
<i>metyrosine (Demser)</i>	T1	PA HD
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC</b>		
<i>clonidine (Catapres-tts 1)</i>	T1	HD
<i>clonidine (Catapres-tts 2)</i>	T1	HD
<i>clonidine (Catapres-tts 3)</i>	T1	HD
<i>clonidine hcl</i>	T1	HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-HYPERTENSIVES, SYMPATHOLYTIC (cont.)</b>		
<i>guanfacine hcl</i>	T1	HD
<i>methyldopa</i>	T1	HD
<i>methyldopa/hydrochlorothiazide</i>	T1	HD
<b>ANTI-HYPERTENSIVES, VASODILATORS</b>		
<i>hydralazine hcl</i>	T1	HD
<i>minoxidil</i>	T1	HD
<b>BETA-ADRENERGIC BLOCKING AGENTS</b>		
<i>acebutolol hcl</i>	T1	HD
<i>atenolol</i> (Tenormin)	T1	HD
<i>betaxolol hcl</i>	T1	HD
<i>bisoprolol fumarate 10 mg tab</i>	T1	HD
<i>bisoprolol fumarate 5 mg tab</i>	T1	HD
<i>metoprolol succinate</i> (Toprol XL)	T1	HD
<i>metoprolol tartrate</i>	T1	HD
<i>metoprolol tartrate</i> (Lopressor)	T1	HD
<i>nadolol</i>	T1	HD
<i>nebivolol 10 mg tablet</i> (Bystolic)	T1	HD
<i>nebivolol 2.5 mg tablet</i> (Bystolic)	T1	HD
<i>nebivolol 20 mg tablet</i> (Bystolic)	T1	HD
<i>nebivolol 5 mg tablet</i> (Bystolic)	T1	HD
<i>pindolol</i>	T1	HD
<i>propranolol hcl</i>	T1	HD
<i>propranolol hcl</i> (Inderal La)	T1	HD
<i>sotalol hcl</i> (Betapace Af)	T1	HD
<i>sotalol hcl</i> (Betapace)	T1	HD
SOTYLIZE	T3	HD
<i>timolol maleate</i>	T1	HD
<b>BETA-BLOCKERS AND THIAZIDE, THIAZIDE-LIKE DIURETICS</b>		
<i>atenolol/chlorthalidone</i> (Tenoretic 100)	T1	HD
<i>atenolol/chlorthalidone</i> (Tenoretic 50)	T1	HD
<i>bisoprolol/hydrochlorothiazide</i>	T1	HD
<i>metoprolol/hydrochlorothiazide</i>	T1	HD
<i>propranolol/hydrochlorothiazid</i>	T1	HD

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

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## List of Prescription Medications

### CARDIOVASCULAR (Blood Pressure/Heart Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RENIN INHIBITOR, DIRECT</b>		
<i>aliskiren 150 mg tablet</i> (Tekturna)	T1	QL(1 TAB/DAY) HD
<i>aliskiren 300 mg tablet</i> (Tekturna)	T1	HD
<b>VASODILATORS, COMBINATION</b>		
<i>isosorbide-hydralazine 20-37.5</i> (Bidil)	T1	QL(6 TABS/DAY) HD
<b>VASODILATORS, PERIPHERAL</b>		
<i>ergoloid mesylates</i>	T1	
<i>isoxsuprine hcl</i>	T1	

### CARDIOVASCULAR (Cholesterol Medications)

<b>ANTI-HYPERLIPID.HMG COA REDUCT INHIB-CHOLEST.AB.INHIB</b>		
<i>ezetimibe/simvastatin</i> (Vytorin)	T1	HD
<b>ANTI-HYPERLIPID- HMG-COA RI-CALCIUM CHANNEL BLOCKER</b>		
<i>amlodipine-atorvast 10-10 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-20 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-40 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 10-80 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 2.5-10 mg</i>	T1	HD
<i>amlodipine-atorvast 2.5-20 mg</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 2.5-40 mg</i>	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-10 mg</i> (Caduet)	T1	HD
<i>amlodipine-atorvast 5-20 mg</i> (Caduet)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-40 mg</i> (Caduet)	T1	QL(1 TAB/DAY) HD
<i>amlodipine-atorvast 5-80 mg</i> (Caduet)	T1	HD
CADUET 5 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 5 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	QL(1 TAB/DAY) HD
CADUET 5 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-10 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-20 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-40 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD
CADUET 10 MG-80 MG TABLET ( <i>amlodipine-atorvastatin</i> )	T3	HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIHYPERLIPIDEMIC - APOLIPOPROTEIN INHIBITOR</b>		
TRYNGOLZA	T3	PA QL(1 AUTO-INJ/28 DAYS) SP
<b>ANTI-HYPERLIPIDEMIC - PCSK9 INHIBITORS</b>		
REPATHA PUSHTRONEX	T2	
REPATHA SURECLICK	T2	
REPATHA SYRINGE	T2	
<b>ANTI-HYPERLIPIDEMIC-HMGCOA REDUCTASE INHIB (Statins)</b>		
<i>atorvastatin 10 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 20 mg tablet</i>	T1	HD PPACA
<i>atorvastatin 40 mg tablet</i>	T1	HD
<i>atorvastatin 80 mg tablet</i>	T1	HD
<i>fluvastatin sodium</i>	T1	HD PPACA
<i>fluvastatin sodium (Lescol XL)</i>	T1	HD PPACA
<i>lovastatin 10 mg tablet</i>	T1	HD
<i>lovastatin 20 mg tablet</i>	T1	HD PPACA
<i>lovastatin 40 mg tablet</i>	T1	HD PPACA
<i>pitavastatin 1 mg tablet (Livalo)</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>pitavastatin 2 mg tablet (Livalo)</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>pitavastatin 4 mg tablet (Livalo)</i>	T1	HD PPACA
<i>pravastatin sodium</i>	T1	HD PPACA
<i>rosuvastatin calcium 10 mg tab (Crestor)</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>rosuvastatin calcium 20 mg tab (Crestor)</i>	T1	QL(1 TAB/DAY) HD
<i>rosuvastatin calcium 40 mg tab (Crestor)</i>	T1	HD
<i>rosuvastatin calcium 5 mg tab (Crestor)</i>	T1	QL(1 TAB/DAY) HD PPACA
<i>simvastatin 10 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 20 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 40 mg tablet (Zocor)</i>	T1	HD PPACA
<i>simvastatin 5 mg tablet</i>	T1	HD
<i>simvastatin 80 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<b>BILE SALT SEQUESTRANTS</b>		
<i>cholestyramine</i>	T1	HD
<i>cholestyramine (Questran Light)</i>	T1	HD
<i>cholestyramine (with sugar) (Questran)</i>	T1	HD

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BILE SALT SEQUESTRANTS (cont.)</b>		
<i>cholestyramine/aspartame</i>	T1	HD
<i>colesevelam hcl (Welchol)</i>	T1	HD
COLESTID	T3	HD
COLESTID ( <i>colestipol hcl</i> )	T3	HD
<i>colestipol hcl</i>	T1	HD
<i>colestipol hcl (Colestid)</i>	T1	HD
QUESTRAN ( <i>cholestyramine</i> )	T3	HD
QUESTRAN LIGHT ( <i>prevalite</i> )	T3	HD
<b>LIPOTROPICS</b>		
<i>ezetimibe (Zetia)</i>	T1	HD
<i>fenofibrate 120 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 130 mg capsule</i>	T1	HD
<i>fenofibrate 134 mg capsule</i>	T1	HD
<i>fenofibrate 145 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 150 MG CAPSULE	T1	HD
<i>fenofibrate 160 mg tablet</i>	T1	HD
<i>fenofibrate 200 mg capsule</i>	T1	HD
<i>fenofibrate 40 mg tablet (Fenoglide)</i>	T1	HD
<i>fenofibrate 43 mg capsule</i>	T1	HD
<i>fenofibrate 48 mg tablet (Tricor)</i>	T1	HD
FENOFIBRATE 50 MG CAPSULE	T1	HD
<i>fenofibrate 54 mg tablet</i>	T1	HD
<i>fenofibrate 67 mg capsule</i>	T1	HD
<i>fenofibric acid</i>	T1	HD
<i>fenofibric acid (choline)</i>	T1	HD
<i>fenofibric acid (Fibricor)</i>	T1	HD
FIBRICOR ( <i>fenofibric acid</i> )	T3	ST HD
<i>gemfibrozil (Lopid)</i>	T1	HD
LIPOFEN	T3	ST HD
LOPID ( <i>gemfibrozil</i> )	T1	HD
<i>niacin</i>	T3	ST HD
TRICOR ( <i>fenofibrate nanocrystallized</i> )	T3	ST HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CARDIOVASCULAR (Cholesterol Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENDOTHELIN-ANGIOTENSIN RECEPTOR ANTAGONIST</b>		
FILSPARI	T2	PA QL(1 TAB/DAY) SP
<b>CNS DRUGS (Alzheimer's Disease)</b>		
<b>ALZHEIMER'S THERAPY, NMDA RECEPTOR ANTAGONISTS</b>		
<i>memantine hcl</i>	T1	HD
MEMANTINE HCL	T1	HD
<i>memantine hcl er 14 mg capsule (Namenda Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>memantine hcl er 21 mg capsule</i>	T1	HD
<i>memantine hcl er 28 mg capsule (Namenda Xr)</i>	T1	HD
<i>memantine hcl er 7 mg capsule (Namenda Xr)</i>	T1	QL(1 CAP/DAY) HD
NAMENDA	T3	HD
NAMENDA XR TITRATION PACK	T3	QL(112 CAPS/365 DAYS) HD
<b>ALZHEIMER'S THX, NMDA RECEPTOR ANTAG-CHOLINES INHIB</b>		
<i>memantine hcl/donepezil hcl (Namzaric)</i>	T1	QL(2 CAPS/DAY) HD
<b>CNS DRUGS (Miscellaneous)</b>		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>AMYOTROPHIC LATERAL SCLEROSIS AGENTS</b>		
RADICAVA ORS 105 MG/5 ML SUSP	T3	PA QL(50 MLS/30 DAYS) SP HD
RADICAVA ORS STARTER KIT SUSP	T3	PA QL(70 MLS/365 DAYS) SP HD
<i>riluzole (Rilutek)</i>	T1	SP HD
TEGLUTIK	T3	PA SP
TIGLUTIK	T3	PA SP
<b>DRUGS TO TREAT MOVEMENT DISORDERS</b>		
AUSTEDO XR 12 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 18 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 24 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
AUSTEDO XR 30 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 36 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 42 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 48 MG TABLET	T3	PA QL(1 TAB/DAY) SP HD
AUSTEDO XR 6 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
AUSTEDO XR TITRATION KT(WK1-4)	T3	PA QL(1 KIT/180 DAYS) SP HD
INGREZZA	T3	PA QL(1 CAP/DAY) SP

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CNS DRUGS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT MOVEMENT DISORDERS (cont.)</b>		
INGREZZA INITIATION PK(TARDIV)	T3	PA QL(28 CAPS/365 DAYS) SP
INGREZZA SPRINKLE	T3	PA QL(1 CAP/DAY) SP
<i>tetrabenazine (Xenazine)</i>	T1	PA SP HD
<b>PSEUDOBULBAR AFFECT (PBA) AGENTS, NMDA ANTAGONISTS</b>		
NUEDEXTA	T3	QL(4 CAPS/DAY)
<b>XANTHINES</b>		
<i>caffeine citrate</i>	T1	HD
<b>CNS DRUGS (Multiple Sclerosis)</b>		
<b>AGENTS TO TREAT MULTIPLE SCLEROSIS</b>		
AVONEX (4 PACK)	T2	PA SP HD
AVONEX PEN (4 PACK)	T2	PA SP HD
BAFIERTAM	T2	PA SP HD
BETASERON	T2	PA SP HD
<i>cladribine</i>	T1	PA SP HD
<i>dimethyl fumarate 30d start pk (Tecfidera)</i>	T1	SP HD
<i>dimethyl fumarate dr 120 mg cp (Tecfidera)</i>	T1	SP HD
<i>dimethyl fumarate dr 240 mg cp (Tecfidera)</i>	T1	SP HD
<i>fingolimod hcl (Gilenya)</i>	T1	SP HD
<i>glatiramer acetate (Copaxone)</i>	T1	SP HD
KESIMPTA PEN	T2	PA SP HD
MAVENCLAD	T3	PA SP HD
MAYZENT	T2	PA SP HD
PLEGRIDY	T2	PA SP HD
PLEGRIDY PEN	T2	PA SP HD
REBIF	T2	PA SP HD
REBIF REBIDOSE	T2	PA SP HD
<i>teriflunomide (Aubagio)</i>	T1	SP HD
VUMERITY	T2	PA SP HD
<b>AGTS TX NEUROMUSC TRANSMISSION DIS, POT-CHAN BLKR</b>		
<i>dalfampridine er 10 mg tablet (Ampyra)</i>	T1	PA SP HD
FIRDAPSE	T3	PA QL(8 TABS/DAY) SP

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CNS DRUGS (Multiple Sclerosis) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
ZEPOSIA	T2	PA SP HD
<b>CNS DRUGS (Pain Relief And Inflammatory Disease)</b>		
<b>CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS</b>		
EMGALITY SYRINGE	T2	PA
<b>POSTHERPETIC NEURALGIA AGENTS</b>		
<i>gabapentin</i> (Gralise)	T1	
GRALISE ER 300 MG TABLET ( <i>gabapentin</i> )	T3	
GRALISE ER 600 MG TABLET ( <i>gabapentin</i> )	T3	
<b>SPHINGOSINE I-PHOSPHATE (SIP) RECEPTOR MODULATOR</b>		
VELSIPITY	T2	PA QL(30 TABS/30 DAYS) SP HD
ZEPOSIA	T2	PA SP HD
<b>CNS DRUGS (Seizure Disorders)</b>		
<b>ANTI-CONVULSANT - BENZODIAZEPINE TYPE</b>		
<i>clobazam</i> (Onfi)	T1	HD
<i>clonazepam</i>	T1	HD
<i>clonazepam</i> (Klonopin)	T1	HD
DIASTAT ( <i>diazepam</i> )	T3	PA HD
<i>diazepam 10 mg rectal gel syrg</i>	T1	HD
<i>diazepam 10mg rectal gel (2pk)</i>	T1	HD
<i>diazepam 2.5mg rectal gel(2pk)</i> (Diastat)	T1	HD
<i>diazepam 20 mg rectal gel syrg</i>	T1	HD
<i>diazepam 20mg rectal gel (2pk)</i>	T1	HD
KLONOPIN ( <i>clonazepam</i> )	T3	PA HD
NAYZILAM	T2	PA QL(10 UNITS/30 DAYS) HD
VALTOCO	T2	PA QL(10 BLISTER PACKS/30 DAYS) HD
<b>ANTI-CONVULSANT - CANNABINOID TYPE</b>		
EPIDIOLEX	T3	PA SP HD
BRIVIACT	T3	PA HD
<i>carbamazepine</i> (Carbatrol)	T1	HD
<i>carbamazepine</i> (Tegretol Xr)	T1	HD
<i>carbamazepine</i> (Tegretol)	T1	HD
<i>carbamazepine 100 mg tab chew</i>	T1	HD
<i>carbamazepine 100 mg/5 ml cup</i>	T1	HD

T1 – Typically Generics

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AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>carbamazepine 100 mg/5 ml susp</i> (Tegretol)	T1	HD
CARBAMAZEPINE 200 MG TAB CHEW	T3	HD
<i>carbamazepine 200 mg tablet</i> (Tegretol)	T1	HD
<i>carbamazepine 200 mg/10 ml cup</i>	T1	HD
CARBATROL ( <i>carbamazepine</i> )	T3	PA HD
CELONTIN ( <i>methsuximide</i> )	T3	HD
DIACOMIT	T3	PA SP HD
DILANTIN 100 MG CAPSULE ( <i>phenytoin sodium extended</i> )	T3	PA HD
DILANTIN 30 MG CAPSULE	T2	PA HD
DILANTIN 50 MG INFATAB ( <i>phenytoin</i> )	T3	PA HD
DILANTIN-125 ( <i>phenytoin</i> )	T3	PA HD
<i>divalproex sodium</i> (Depakote Er)	T1	HD
<i>divalproex sodium</i> (Depakote Sprinkle)	T1	HD
<i>divalproex sodium</i> (Depakote)	T1	HD
<i>eslicarbazepine 200 mg tablet</i> (Aptiom)	T1	PA QL(1 TAB/DAY) HD
<i>eslicarbazepine 400 mg tablet</i> (Aptiom)	T1	PA QL(1 TAB/DAY) HD
<i>eslicarbazepine 600 mg tablet</i> (Aptiom)	T1	PA HD
<i>eslicarbazepine 800 mg tablet</i> (Aptiom)	T1	PA HD
<i>ethosuximide</i> (Zarontin)	T1	HD
<i>felbamate</i> (Felbatol)	T1	HD
FINTEPLA	T3	PA SP HD
FYCOMPA 0.5 MG/ML ORAL SUSP	T2	PA HD
<i>gabapentin</i>	T1	HD
<i>gabapentin</i> (Neurontin)	T1	HD
<i>lacosamide</i> (Vimpat)	T1	HD
<i>lamotrigine</i> (Lamictal (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal (Green))	T1	HD
<i>lamotrigine</i> (Lamictal (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Blue))	T1	HD
<i>lamotrigine</i> (Lamictal Odt (Green))	T1	HD

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>lamotrigine</i> (Lamictal Odt (Orange))	T1	HD
<i>lamotrigine</i> (Lamictal Odt)	T1	HD
<i>lamotrigine</i> (Lamictal Xr)	T1	HD
<i>lamotrigine</i> (Lamictal)	T1	HD
<i>levetiracetam</i> (Keppra Xr)	T1	HD
<i>levetiracetam</i> (Keppra)	T1	HD
<i>levetiracetam 1,000 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 1,000mg/10ml cup</i> (Keppra)	T1	HD
<i>levetiracetam 100 mg/ml soln</i> (Keppra)	T1	HD
LEVETIRACETAM 250 MG TAB SUSP	T3	PA HD
<i>levetiracetam 250 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg tablet</i> (Keppra)	T1	HD
<i>levetiracetam 500 mg/5 ml cup</i>	T1	HD
<i>levetiracetam 500 mg/5 ml soln</i>	T1	HD
<i>levetiracetam 750 mg tablet</i> (Keppra)	T1	HD
LYRICA 20 MG/ML ORAL SOLUTION ( <i>pregabalin</i> )	T3	PA HD
<i>methsuximide</i> (Celontin)	T1	HD
NEURONTIN 400 MG CAPSULE ( <i>gabapentin</i> )	T3	HD
NEURONTIN 600 MG TABLET ( <i>gabapentin</i> )	T3	HD
NEURONTIN 800 MG TABLET ( <i>gabapentin</i> )	T3	HD
<i>oxcarbazepine</i> (Oxtellar Xr)	T1	PA HD
<i>oxcarbazepine</i> (Trileptal)	T1	HD
OXTELLAR XR ( <i>oxcarbazepine</i> )	T3	PA HD
<i>perampanel 10 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 12 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 2 mg tablet</i> (Fycompa)	T1	PA HD
<i>perampanel 4 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 6 mg tablet</i> (Fycompa)	T1	PA QL(1 TAB/DAY) HD
<i>perampanel 8 mg tablet</i> (Fycompa)	T1	PA HD
PHENYTEK ( <i>phenytoin sodium extended</i> )	T3	PA HD

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>phenytoin</i>	T1	HD
<i>phenytoin (Dilantin)</i>	T1	HD
<i>phenytoin (Dilantin-125)</i>	T1	HD
<i>phenytoin sodium extended (Dilantin)</i>	T1	HD
<i>phenytoin sodium extended (Phenytek)</i>	T1	HD
<i>pregabalin (Lyrica)</i>	T1	HD
<i>primidone 250 mg tablet (Mysoline)</i>	T1	HD
<i>primidone 50 mg tablet (Mysoline)</i>	T1	HD
<i>rufinamide 200 mg tablet (Banzel)</i>	T1	PA QL(16 TABS/DAY) HD
<i>rufinamide 40 mg/ml suspension (Banzel)</i>	T1	PA QL(80 MLS/DAY) HD
<i>rufinamide 400 mg tablet (Banzel)</i>	T1	PA QL(8 TABS/DAY) HD
SPRITAM	T3	PA HD
<i>subvenite 100 mg tablet (Lamictal)</i>	T1	HD
<i>subvenite 150 mg tablet (Lamictal)</i>	T1	HD
<i>subvenite 200 mg tablet (Lamictal)</i>	T1	HD
<i>subvenite 25 mg tablet (Lamictal)</i>	T1	HD
TEGRETOL ( <i>carbamazepine</i> )	T3	PA HD
TEGRETOL XR ( <i>carbamazepine</i> )	T3	PA HD
<i>tiagabine hcl 12 mg tablet</i>	T1	QL(8 TABS/DAY) HD
<i>tiagabine hcl 16 mg tablet</i>	T1	QL(6 TABS/DAY) HD
<i>tiagabine hcl 2 mg tablet</i>	T1	HD
<i>tiagabine hcl 4 mg tablet</i>	T1	HD
<i>topiramate (Qudexy Xr)</i>	T1	HD
<i>topiramate 100 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 15 mg sprinkle cap (Topamax)</i>	T1	HD
<i>topiramate 200 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 25 mg sprinkle cap (Topamax)</i>	T1	HD
<i>topiramate 25 mg tablet (Topamax)</i>	T1	HD
<i>topiramate 25 mg/ml solution (Eprontia)</i>	T1	HD
<i>topiramate 50 mg sprinkle cap</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### CNS DRUGS (Seizure Disorders) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-CONVULSANTS (cont.)</b>		
<i>topiramate 50 mg tablet (Topamax)</i>	T1	HD
<i>topiramate er 100 mg capsule (Trokendi Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>topiramate er 200 mg capsule (Trokendi Xr)</i>	T1	HD
<i>topiramate er 25 mg capsule (Trokendi Xr)</i>	T1	QL(1 CAP/DAY) HD
<i>topiramate er 50 mg capsule (Trokendi Xr)</i>	T1	HD
TROKENDI XR 100 MG CAPSULE ( <i>topiramate</i> )	T3	QL(1 CAP/DAY) HD
TROKENDI XR 200 MG CAPSULE ( <i>topiramate</i> )	T3	HD
TROKENDI XR 25 MG CAPSULE ( <i>topiramate</i> )	T3	QL(1 CAP/DAY) HD
TROKENDI XR 50 MG CAPSULE ( <i>topiramate</i> )	T3	HD
<i>valproic acid</i>	T1	HD
<i>valproic acid (as sodium salt)</i>	T1	HD
<i>vigabatrin (Sabril)</i>	T1	SP HD
<i>vigadrone 500 mg powder packet (Sabril)</i>	T1	SP HD
VIMPAT 10 MG/ML SOLUTION ( <i>lacosamide</i> )	T2	HD
XCOPRI 100 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 12.5-25 MG TITRATION PK	T3	PA QL(28 TABS/28 DAYS) HD
XCOPRI 150 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 150-200 MG TITRATION PK	T3	PA QL(28 TABS/28 DAYS) HD
XCOPRI 200 MG TABLET	T3	PA QL(2 TABS/DAY) HD
XCOPRI 25 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 250 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 350 MG DAILY DOSE PACK	T3	PA QL(56 TABS/28 DAYS) HD
XCOPRI 50 MG TABLET	T3	PA QL(1 TABLET/DAY) HD
XCOPRI 50-100 MG TITRATION PAK	T3	PA QL(28 TABS/28 DAYS) HD
ZARONTIN ( <i>ethosuximide</i> )	T3	PA HD
<i>zonisamide</i>	T1	HD
<i>zonisamide (Zonegran)</i>	T1	HD

### CNS DRUGS (Sleep Disorders/Sedatives)

#### NARCOLEPSY TX-H3-RECEPT.ANTAGONIST/INVERSE AGONIST

WAKIX	T3	PA QL(2 TABS/DAY) SP HD
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T1 – Typically Generics

T2 – Typically Preferred Brands

T3 – Typically Non-Preferred Brands

PA – Prior Authorization

QL – Quantity Limit

ST – Step Therapy

AGE – Age Requirement

SP – Specialty Medication

HD – May require home delivery pharmacy

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CSL – Oral cancer medication subject to cost-share limits

## List of Prescription Medications

### COLONY STIMULATING FACTORS (Blood Modifiers/Bleeding Disorders)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ERYTHROPOIESIS-STIMULATING AGENTS</b>		
ARANESP	T2	PA SP
EPOGEN	T2	PA SP
MIRCERA	T3	PA SP
PROCRIT	T2	PA SP
RETACRIT	T2	PA SP
<b>LEUKOCYTE (WBC) STIMULANTS</b>		
FULPHILA	T3	PA SP
FYLNETRA	T3	PA SP
GRANIX	T3	PA SP
LEUKINE	T2	SP
NEULASTA	T2	PA SP
NEULASTA ONPRO	T2	PA SP HD
NEUPOGEN	T3	PA SP
NIVESTYM	T2	SP HD
NYPOZI	T3	PA SP
NYVEPRIA	T2	PA SP
STIMUFEND	T3	PA SP
UDENYCA	T2	PA SP
UDENYCA AUTOINJECTOR	T2	PA SP
UDENYCA ONBODY	T2	PA SP
ZARXIO	T2	SP HD
ZIEXTENZO	T3	PA SP
<b>THROMBOPOIETIN RECEPTOR AGONISTS</b>		
DOPTELET	T2	PA SP HD
DOPTELET SPRINKLE	T2	PA SP HD
<i>eltrombopag olamine</i> (Promacta)	T1	PA SP HD
MULPLETA	T3	PA SP HD
<b>LEUKOCYTE (WBC) STIMULANTS</b>		
RELEUKO	T3	PA SP
ROLVEDON	T2	PA SP
<b>COLONY STIMULATING FACTORS (Cancer)</b>		
<b>Prescription Drug Name</b>		
<b>Drug Tier</b>		
<b>Coverage Requirements and Limits</b>		
<b>CXCR4 CHEMOKINE RECEPTOR ANTAGONIST</b>		
XOLREMDI	T3	PA QL(4 CAPS/DAY) SP CSL

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

CONTRACEPTIVES (Contraception Products)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, INTRAVAGINAL, SYSTEMIC</b>		
<i>etonogestrel/ethinyl estradiol</i> (Nuvaring)	T1	PPACA
<b>CONTRACEPTIVES, IMPLANTABLE</b>		
NEXPLANON	T2	SP PPACA
<b>CONTRACEPTIVES, INJECTABLE</b>		
DEPO-PROVERA ( <i>medroxyprogesterone acetate</i> )	T3	PPACA
DEPO-SUBQ PROVERA 104	T3	PPACA
<i>medroxyprogesterone 150 mg/ml</i> (Depo-Provera)	T1	PPACA
<b>CONTRACEPTIVES, ORAL</b>		
<i>desog-e.estradiol/e.estradiol</i>	T1	HD PPACA
<i>desogestrel-ethinyl estradiol</i>	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Beyaz)	T1	HD PPACA
<i>drospir/eth estra/levomefol ca</i> (Safyral)	T1	HD PPACA
ELLA	T3	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yasmin 28)	T1	HD PPACA
<i>ethinyl estradiol/drospirenone</i> (Yaz)	T1	HD PPACA
<i>ethynodiol d-ethinyl estradiol</i>	T1	HD PPACA
<i>levonorgest/eth.estradiol/iron</i> (Balcoltra)	T1	HD PPACA
<i>levonorgestrel/ethin.estradiol</i>	T1	HD PPACA
<i>l-norgest/e.estradiol-e.estrad</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T1	HD PPACA
<i>noreth-ethinyl estradiol/iron</i>	T3	HD PPACA
<i>norethind-eth estrad 1-0.02 mg</i> (Loestrin)	T1	HD PPACA
<i>norethindrone</i>	T1	HD PPACA
<i>norethindrone ac/eth estradiol</i> (Loestrin)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i>	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Loestrin Fe)	T1	HD PPACA
<i>norethindrone-e.estradiol-iron</i> (Taytulla)	T1	HD PPACA
<i>norethindrone-ethin. estradiol</i>	T1	HD PPACA
<i>norethin-ee 1.5-0.03 mg(21) tb</i> (Loestrin)	T1	HD PPACA
<i>norgestimate-ethinyl estradiol</i>	T1	HD PPACA
<i>norgestrel-ethinyl estradiol</i>	T1	HD PPACA

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

CONTRACEPTIVES (Contraception Products) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CONTRACEPTIVES, TRANSDERMAL</b>		
<i>norelgestromin/ethin.estradiol</i>	T1	HD PPACA
<b>DIAPHRAGMS/CERVICAL CAP</b>		
CAYA CONTOURED	T2	PPACA
FEMCAP	T2	PPACA
WIDE SEAL DIAPHRAGM	T3	PPACA
<b>INTRA-UTERINE DEVICES (IUDS)</b>		
KYLEENA	T3	SP PPACA
LILETTA	T3	SP PPACA
MIRENA	T3	SP PPACA
MIUDELLA	T3	SP PPACA
PARAGARD T 380-A	T3	SP PPACA
PARAGARD T 380A (SINGLE HAND)	T3	SP PPACA
SKYLA	T3	SP PPACA
<b>COUGH/COLD PREPARATIONS (Allergy/Nasal Sprays)</b>		
<b>1ST GEN ANTIHIST-DECONGEST-ANTICHOLINERGIC COMB</b>		
RESPA A.R. ( <i>pseudoephed/chlor-mal/bell alk</i> )	T3	
<b>COUGH/COLD PREPARATIONS (Cough/Cold Medications)</b>		
<b>ANTI-TUSSIVES, NON-OPIOID</b>		
<i>benzonatate 100 mg capsule</i>	T1	
<i>benzonatate 200 mg capsule</i>	T1	
<b>NON-OPIOID ANTI-TUS-1ST GEN.ANTIHISTAMINE-DECONGEST</b>		
<i>brompheniramine/pseudoephed/dm</i> (Bromfed Dm)	T1	
<b>NON-OPIOID ANTI-TUSSIVE-1ST GEN ANTIHISTAMINE COMB.</b>		
<i>promethazine/dextromethorphan</i>	T1	
<b>OPIOID ANTI-TUSSIV-1ST GEN. ANTIHISTAMINE-DECONGEST</b>		
CAPCOF	T3	
HISTEX-AC	T3	
MAXI-TUSS CD	T3	
POLY-TUSSIN AC	T3	
<i>promethazine/phenyleph/codeine</i>	T1	PA QL(480 MLS/30 DAYS)

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# List of Prescription Medications

## COUGH/COLD PREPARATIONS (Cough/Cold Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>OPIOID ANTI-TUSSIVE-1ST GENERATION ANTIHISTAMINE</b>		
<i>hydrocodone/chlorphen p-stirex</i>	T1	PA
<i>promethazine hcl/codeine</i>	T1	PA QL(480 MLS/30 DAYS)
TUXARIN ER	T3	PA QL(2 TABS/DAY)
TUZISTRA XR	T3	PA QL(960 MLS/30 DAYS)
<b>OPIOID ANTI-TUSSIVE-ANTI-CHOLINERGIC COMBINATIONS</b>		
HYCODAN 5 MG-1.5 MG TABLET ( <i>hydrocodone bit/homatrop me-br</i> )	T3	PA QL(180 TABS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML CUP	T3	PA QL(480 MLS/30 DAYS)
HYCODAN 5 MG-1.5 MG/5 ML SOLN ( <i>hydrocodone bit/homatrop me-br</i> )	T3	PA QL(480 MLS/30 DAYS)
<i>hydrocodone bit/homatrop me-br</i> (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
<i>hydrocodone-homatrop 5 ml cup</i>	T1	PA QL(480 MLS/30 DAYS)
<i>hydrocodone-homatropine 5-1.5</i> (Hycodan)	T1	PA QL(180 TABS/30 DAYS)
<i>hydrocodone-homatropine soln</i> (Hycodan)	T1	PA QL(480 MLS/30 DAYS)
<b>OPIOID ANTITUSSIVE-DECONGESTANT-EXPECTORANT COMB</b>		
CODITUSSIN DAC	T3	
<b>OPIOID ANTI-TUSSIVE-EXPECTORANT COMBINATION</b>		
<i>codeine phosphate/guaifenesin</i>	T1	
CODITUSSIN AC	T1	
GUAIFENESIN-CODEINE	T1	
MAR-COF CG	T3	
NINJACOF-XG	T1	
OBREDON	T3	PA QL(960 MLS/30 DAYS)
<b>DIAGNOSTIC (Diabetes)</b>		
<b>BLOOD SUGAR DIAGNOSTICS</b>		
FREESTYLE INSULINX	T2	
FREESTYLE INSULINX TEST STRIPS	T2	
FREESTYLE LITE TEST STRIP	T2	
FREESTYLE PRECISION NEO	T2	
FREESTYLE TEST STRIPS	T2	
PRECISION XTRA TEST STRIPS	T2	
RELION TRUE METRIX TEST STRIP	T2	
TRUE METRIX GLUCOSE TEST STRIP	T2	
<b>URINE GLUCOSE TEST AIDS</b>		
DIASTIX REAGENT	T1	

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# List of Prescription Medications

DIAGNOSTIC (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BLOOD TESTING PREPARATIONS</b>		
FORA GTEL KETONE TEST STRIP	T1	
FORA TN'G ADV VOICE KETO STRIP	T1	
GOJJI BLOOD KETONE TEST STRIP	T1	
NOVAMAX PLUS	T1	
PRECISION XTR B-KETONE STRIP	T1	
<b>DIAGNOSTIC PREPARATIONS, MISCELLANEOUS</b>		
ADVANCED DNA MEDICATED COLLECT	T3	
ARIDOL	T3	
<i>lidocaine hcl/glycerin</i>	T1	
PROVOCHOLINE	T3	
TC 99M SULFUR COLLOID PREP	T1	
<b>EYE DIAGNOSTIC AGENTS</b>		
<i>fluorescein sodium</i>	T1	
<i>ful-glo 1 mg ophth strip</i>	T1	
FUL-GLO EYE STRIPS	T3	
<i>lissamine green</i>	T1	
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS</b>		
<i>diatrizoate meglumine, sodium</i> (Gastrografin)	T1	
ENTERO VU	T3	
E-Z DISK	T3	
E-Z-HD	T3	
E-Z-PAQUE	T3	
E-Z-PASTE	T3	
GASTROGRAFIN ( <i>diatrizoate meglumine, sodium</i> )	T3	
GASTROMARK	T3	
LIQUID E-Z PAQUE	T3	
LIQUID POLIBAR PLUS	T3	
NEULUMEX	T3	
POLIBAR ACB	T3	
READI-CAT 2	T3	
SITZMARKS	T3	
TAGITOL V	T3	

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## List of Prescription Medications

### DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GASTROINTESTINAL RADIOPAQUE DIAGNOSTICS (cont.)</b>		
VANILLA SILQ	T3	
VARIBAR HONEY	T3	
VARIBAR NECTAR	T3	
VARIBAR PUDDING	T3	
VARIBAR THIN HONEY	T3	
VARIBAR THIN LIQUID	T3	
<b>METABOLIC FUNCTION DIAGNOSTICS</b>		
METOPIRONE	T3	
<b>RADIOPHARMACEUTICALS ELEMENTS</b>		
INDICLOR	T3	
<b>URINARY TRACT RADIOPAQUE DIAGNOSTICS</b>		
CYSTO-CONRAY II	T3	
CYSTOGRAFIN	T3	
CYSTOGRAFIN-DILUTE	T3	
<b>URINE ACETONE TEST AIDS</b>		
KETONE CARE TEST STRIP	T1	
KETONE TEST STRIP	T1	
KETOSTIX REAGENT	T1	
TRUEPLUS KETONE TEST STRIP	T1	
<b>URINE MULTIPLE TEST AIDS</b>		
CHEK-STIX	T1	
CHEMSTRIP	T1	
CHEMSTRIP 10 WITH SG	T1	
CHEMSTRIP 2 GP	T1	
CHEMSTRIP 50B	T1	
CHEMSTRIP 7	T1	
CHEMSTRIP 9	T1	
COMBISTIX REAGENT	T1	
HEMA-COMBISTIX	T1	
KETO-DIASTIX REAGENT	T1	
LABSTIX REAGENT	T1	
MULTISTIX	T1	
MULTISTIX 10 SG	T1	
MULTISTIX 5	T1	

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## List of Prescription Medications

### DIAGNOSTIC (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINE MULTIPLE TEST AIDS (cont.)</b>		
MULTISTIX 7	T1	
MULTISTIX 8 SG	T1	
MULTISTIX 9	T1	
MULTISTIX 9 SG	T1	
URISTIX 4	T1	
URISTIX REAGENT	T1	
<b>DIURETICS (Diuretics)</b>		
<b>ARGININE VASOPRESSIN (AVP) RECEPTOR ANTAGONISTS</b>		
<i>tolvaptan 15 mg tablet (Samsca)</i>	T1	SP
<i>tolvaptan 30 mg tablet (Samsca)</i>	T1	SP
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<i>acetazolamide</i>	T1	HD
<i>methazolamide</i>	T1	HD
<b>LOOP DIURETICS</b>		
<i>bumetanide</i>	T1	HD
<i>furosemide</i>	T1	HD
<i>furosemide (Lasix)</i>	T1	HD
<i>toremide</i>	T1	HD
<b>POLYCYSTIC KIDNEY DISEASE AGENT, AVP RECEPTOR ANTAGONIST</b>		
<i>tolvaptan 15 mg tablet (Jynarque)</i>	T1	SP
<i>tolvaptan 15 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 30 mg tablet (Jynarque)</i>	T1	SP
<i>tolvaptan 30 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 45 mg-15 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 60 mg-30 mg tablet (Jynarque)</i>	T1	PA SP
<i>tolvaptan 90 mg-30 mg tablet (Jynarque)</i>	T1	PA SP
<b>POTASSIUM SPARING DIURETICS</b>		
<i>amiloride hcl</i>	T1	HD
CAROSPIR ( <i>spironolactone</i> )	T2	PA
<i>eplerenone (Inspra)</i>	T1	HD
KERENDIA	T2	PA QL(1 TAB/DAY)
<i>spironolactone 100 mg tablet (Aldactone)</i>	T1	HD
<i>spironolactone 25 mg tablet (Aldactone)</i>	T1	HD

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## List of Prescription Medications

### DIURETICS (Diuretics) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM SPARING DIURETICS (cont.)</b>		
<i>spironolactone 25 mg/5 ml susp (Carospir)</i>	T1	
<i>spironolactone 50 mg tablet (Aldactone)</i>	T1	HD
<i>triamterene (Dyrenium)</i>	T1	HD
<b>POTASSIUM SPARING DIURETICS IN COMBINATION</b>		
<i>amiloride/hydrochlorothiazide</i>	T1	HD
<i>spironolact/hydrochlorothiazid</i>	T1	HD
<i>triamterene/hydrochlorothiazid</i>	T1	HD
<b>THIAZIDE AND RELATED DIURETICS</b>		
<i>chlorthalidone</i>	T1	HD
DIURIL	T3	HD
<i>hydrochlorothiazide</i>	T1	HD
<i>indapamide</i>	T1	HD
<i>metolazone</i>	T1	HD
<b>EENT PREPS (Allergy/Nasal Sprays)</b>		
<b>NASAL ANTIHISTAMINE</b>		
<i>azelastine 0.1% (137 mcg) spray</i>	T1	HD
<i>olopatadine 665 mcg nasal spray (Patanase)</i>	T1	HD
PATANASE ( <i>olopatadine hcl</i> )	T3	HD
<b>NASAL ANTIHISTAMINE AND ANTI-INFLAM. STEROID COMB.</b>		
<i>azelastine/fluticasone (Dymista)</i>	T1	HD
<b>NASAL ANTI-INFLAMMATORY STEROIDS</b>		
<i>flunisolide</i>	T1	HD
<i>fluticasone prop 50 mcg spray</i>	T1	HD
<i>mometasone furoate 50 mcg spray</i>	T1	QL(68 GMS/30 DAYS) HD
<b>NOSE PREPARATIONS, MISCELLANEOUS (RX)</b>		
<i>ipratropium bromide</i>	T1	HD
<b>NOSE PREPARATIONS, VASOCONSTRICTORS (RX)</b>		
ADRENALIN CHLORIDE	T3	
<i>epinephrine hcl</i>	T1	
<b>EENT PREPS (Ear Medications)</b>		
<b>EAR PREPARATIONS ANTI-INFLAMMATORY</b>		
DERMOTIC ( <i>fluocinolone acetonide oil</i> )	T3	
<i>fluocinolone acetonide oil (Dermotic)</i>	T1	

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# List of Prescription Medications

## EENT PREPS (Ear Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EAR PREPARATIONS, MISC. ANTI-INFECTIVES</b>		
<i>acetic acid</i>	T1	
<i>hydrocortisone/acetic acid</i>	T1	
<b>EENT PREPS (Eye Conditions)</b>		
<b>ARTIFICIAL TEARS</b>		
LACRISERT	T3	
MIEBO	T2	QL(4 BOTTLES/30 DAYS)
<b>EYE ANTI-INFECTIVES (RX ONLY)</b>		
BETADINE	T3	
<b>EYE ANTI-INFLAMMATORY AGENTS</b>		
<i>bromfenac sodium</i>	T1	
<i>bromfenac sodium (Bromsite)</i>	T1	
<i>bromfenac sodium (Prolensa)</i>	T1	
<i>dexamethasone sodium phosphate</i>	T1	
<i>diclofenac 0.1% eye drops</i>	T1	
<i>difluprednate (Durezol)</i>	T1	
EYSUVIS	T2	QL(8.3 ML/14 DAYS)
<i>fluorometholone (Fml)</i>	T1	
<i>flurbiprofen sodium</i>	T1	
ILEVRO	T3	
<i>ketorolac 0.4% ophth solution (Acular Ls)</i>	T1	
<i>ketorolac 0.5% ophth solution (Acular)</i>	T1	
<i>loteprednol etabonate (Alrex)</i>	T1	
<i>loteprednol etabonate (Lotemax)</i>	T1	
<i>prednisolone acetate (Pred Forte)</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
PROLENSA ( <i>bromfenac sodium</i> )	T3	
<b>EYE LOCAL ANESTHETICS</b>		
AKTEN	T3	
ALCAINE ( <i>proparacaine hcl</i> )	T3	
ALTAFLUOR BENOX ( <i>benoxinate hcl/fluorescein sod</i> )	T3	
FLUORESCEIN-BENOXINATE	T3	
<i>proparacaine hcl (Alcaine)</i>	T1	

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# List of Prescription Medications

## EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>EYE LOCAL ANESTHETICS (cont.)</b>		
<i>proparacaine/fluorescein sod</i>	T1	
<i>tetracaine hcl</i>	T1	
TETRACAINE HCL	T1	
<b>EYE MAST CELL STABILIZERS</b>		
<i>cromolyn 4% eye drops</i>	T1	
<b>EYE PREPARATIONS, MISCELLANEOUS (OTC)</b>		
GELFILM	T3	
<b>EYE VASOCONSTRICTORS</b>		
<i>phenylephrine hcl</i>	T1	
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS</b>		
<i>apraclonidine hcl</i>	T1	HD
<i>betaxolol hcl</i>	T1	HD
BETOPTIC S	T2	HD
<i>bimatoprost</i>	T1	QL(10 MLS/30 DAYS) HD
<i>brimonidine tartrate</i>	T1	HD
<i>brimonidine tartrate (Alphagan P)</i>	T1	HD
<i>brimonidine tartrate/timolol (Combigan)</i>	T1	HD
<i>brinzolamide (Azopt)</i>	T1	HD
<i>carteolol hcl</i>	T1	HD
<i>dorzolamide hcl</i>	T1	HD
<i>dorzolamide hcl/timolol maleat (Cosopt)</i>	T1	HD
<i>dorzolamide/timolol/pf (Cosopt Pf)</i>	T1	HD
<i>latanoprost (Xalatan)</i>	T1	HD
<i>levobunolol hcl</i>	T1	HD
PHOSPHOLINE IODIDE	T3	SP HD
<i>pilocarpine 1% eye drops</i>	T1	HD
<i>pilocarpine 2% eye drops</i>	T1	HD
<i>pilocarpine 4% eye drops</i>	T1	HD
RHOPRESSA	T3	
ROCKLATAN	T3	
SIMBRINZA	T2	HD
<i>tafluprost/pf (Zioptan)</i>	T1	QL(60 DROPPERS/30 DAYS) HD

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# List of Prescription Medications

## EENT PREPS (Eye Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MIOTICS AND OTHER INTRAOCULAR PRESSURE REDUCERS (cont.)</b>		
<i>timolol</i> (Betimol)	T1	HD
<i>timolol maleate</i> (Istalol)	T1	HD
<i>timolol maleate</i> (Timoptic)	T1	HD
<i>timolol maleate</i> (Timoptic-Xe)	T1	HD
<i>timolol maleate/pf</i>	T1	HD
<i>timolol maleate/pf</i> (Timoptic Ocudose)	T1	HD
<i>travoprost</i> (Travatan Z)	T1	HD
<b>MYDRIATICS</b>		
<i>atropine 1% eye drop</i>	T1	HD
<i>atropine 1% eye drops</i>	T1	HD
<i>atropine 1% eye ointment</i>	T1	HD
CYCLOGYL	T3	HD
CYCLOGYL ( <i>cyclopentolate hcl</i> )	T3	HD
CYCLOMYDRIL	T3	HD
<i>cyclopentolate hcl</i>	T1	HD
<i>cyclopentolate hcl</i> (Cyclogyl)	T1	HD
<i>homatropine hbr</i>	T1	HD
MYDRIACYL ( <i>tropicamide</i> )	T3	HD
PAREMYD	T3	HD
<i>tropicamide</i>	T1	HD
<i>tropicamide</i> (Mydracyl)	T1	HD
<b>OPHTHALMIC ANTI-FIBROTIC AGENTS</b>		
MITOSOL	T3	
<b>OPHTHALMIC ANTI-INFLAMMATORY IMMUNOMODULATOR-TYPE</b>		
CEQUA	T2	
<i>cyclosporine 0.05% eye emuls</i> (Restasis)	T1	HD
RESTASIS ( <i>cyclosporine</i> )	T2	HD
XIIDRA	T2	HD
<b>OPHTHALMIC CYSTINE DEPLETING AGENTS</b>		
CYSTADROPS	T3	PA QL(20 MLS/28 DAYS) SP
CYSTARAN 0.44% EYE DROPS	T3	PA QL(120 MLS/28 DAYS) SP

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# List of Prescription Medications

## EENT PREPS (Eye Conditions) (cont.)

**Prescription Drug Name** **Drug Tier** **Coverage Requirements and Limits**

### OPHTHALMIC HUMAN NERVE GROWTH FACTOR (HNGF)

OXERVATE	T3	PA SP HD
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### OPHTHALMIC TRPM8 AGONISTS

TRYPTYR	T3	
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## ELECT/CALORIC/H2O (Cholesterol Medications)

### ORAL LIPID SUPPLEMENTS

DOJOLVI	T3	PA SP HD
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## ELECT/CALORIC/H2O (Dental Products)

### FLUORIDE PREPARATIONS

CLINPRO 5000	T3	
FLORIVA 0.25 MG/ML DROPS	T3	
fluoride (sodium)	T1	
fluoride (sodium) (Prevident 5000 Plus)	T1	
fluoride (sodium) (Prevident)	T1	
FLUORIDEX	T1	
FLUORIDEX SENSITIVITY RELIEF	T3	
FLUORIMAX 5000	T3	
FLUORIMAX 5000 SENSITIVE	T3	
FRAICHE 5000 PREVI	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT (fluoride (sodium))	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ENAMEL PROTECT	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT 5000 SENSITIVE	T3	
PREVIDENT KIDS	T3	
sodium fluoride 0.2% rinse (Prevident)	T1	
sodium fluoride 1.1% cream (Prevident 5000 Plus)	T1	
sodium fluoride 1.1% gel (Prevident)	T1	
sodium fluoride 5000 ppm paste	T1	
sodium fluoride/potassium nit	T1	

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## List of Prescription Medications

### ELECT/CALORIC/H2O (Dental Products) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
<i>fluoride (sodium)</i>	T1	PPACA
<i>sodium fluoride 0.25 (0.55) mg</i>	T1	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T1	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T1	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T1	PPACA
<b>ELECT/CALORIC/H2O (Diabetes)</b>		
<b>AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS)</b>		
BAQSIMI	T2	QL(2 UNITS/30 DAYS)
<i>diazoxide (Proglycem)</i>	T1	
<i>glucagon 1 mg emergency kit</i>	T1	QL(2 VIALS/30 DAYS)
GLUCAGON 1 MG EMERGENCY KIT	T3	QL(2 KITS/30 DAYS)
ZEGALOGUE AUTOINJECTOR	T2	QL(1.2 ML/30 DAYS)
ZEGALOGUE SYRINGE	T2	QL(1.2 ML/30 DAYS)
<b>ELECT/CALORIC/H2O (Miscellaneous)</b>		
<b>NUCLEIC ACID/NUCLEOTIDE SUPPLEMENTS</b>		
XURIDEN	T3	PA SP
<b>ELECT/CALORIC/H2O (Nutritional/Dietary)</b>		
<b>CALCIUM REPLACEMENT</b>		
<i>calcium/mag/d3/b12/fa/b6/boron</i>	T1	
<b>CARBOHYDRATES</b>		
ENFAMIL	T3	
GLUTOL	T3	
<b>ELECTROLYTE DEPLETERS</b>		
AURYXIA	T3	QL (12 TABS/DAY)
<i>calcium acetate</i>	T1	
<i>lanthanum carbonate (Fosrenol)</i>	T1	
LOKELMA	T2	
MAGNEBIND 400	T3	
<i>sevelamer carbonate (Renvela)</i>	T1	
<i>sevelamer hcl</i>	T1	
<i>sodium polystyrene sulfon/sorb</i>	T1	

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ELECTROLYTE DEPLETERS (cont.)</b>		
<i>sodium polystyrene sulfonate</i>	T1	
<i>sps 15 gm/60 ml suspension</i>	T1	
<i>sps 30 gm/120 ml enema susp</i>	T3	
VELPHORO	T2	
VELTASSA	T2	
<b>FLUORIDE PREPARATIONS</b>		
CLINPRO 5000	T3	
<i>fluoride (sodium)</i>	T1	
<i>fluoride (sodium) (Prevident 5000 Plus)</i>	T1	
<i>fluoride (sodium) (Prevident)</i>	T1	
FLUORIDEX	T1	
FLUORIMAX 5000	T3	
JUST RIGHT 5000	T3	
PREVIDENT	T3	
PREVIDENT ( <i>fluoride (sodium)</i> )	T3	
PREVIDENT 5000 DRY MOUTH	T3	
PREVIDENT 5000 ORTHO DEFENSE	T3	
PREVIDENT KIDS	T3	
<i>sodium fluoride 0.2% rinse (Prevident)</i>	T1	
<i>sodium fluoride 1.1% cream (Prevident 5000 Plus)</i>	T1	
<i>sodium fluoride 1.1% gel (Prevident)</i>	T1	
<i>sodium fluoride 5000 ppm paste</i>	T1	
<b>IODINE CONTAINING AGENTS</b>		
<i>potassium iodide</i>	T1	
<i>potassium iodide/iodine</i>	T1	
SSKI	T3	
<b>IRON REPLACEMENT</b>		
ACCRUFER	T3	
ACTIVE FE	T3	
CITRANATAL BLOOM	T3	
CORVITE 150	T3	
CORVITE FE	T3	
FERIVA 21-7	T3	

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## List of Prescription Medications

### ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRON REPLACEMENT (cont.)</b>		
FERRALET 90	T3	
<i>ferrous fum/vit c/b12-if/folic</i>	T1	
<i>ferrous fumarate/folic acid (Hemocyte-F)</i>	T1	
FUSION PLUS	T3	
HEMATRON-AF	T3	
HEMAX	T3	
HEMOCYTE PLUS ( <i>mv-mins no.73/iron fum/folic</i> )	T3	
HEMOCYTE-F ( <i>ferrous fumarate/folic acid</i> )	T3	
INTEGRA F ( <i>iron fum,ps/folic acid/vitc/b3</i> )	T3	
INTEGRA PLUS ( <i>iron fum,ps/folic/bcomp,c no.9</i> )	T3	
<i>iron aspgly,ps/c/b12/fa/ca/suc</i>	T1	
<i>iron aspgly/c/b12/fa/ca-th/suc</i>	T1	
<i>iron bg,ps/vitc/b12/fa/calcium</i>	T1	
<i>iron fum,ag/c/b12/folic/ca/suc</i>	T1	
<i>iron fum,ps/folic acid/vitc/b3 (Integra F)</i>	T1	
<i>iron fum,ps/folic/bcomp,c no.9 (Integra Plus)</i>	T1	
<i>iron fumarate/vit c/vit b12/fa</i>	T1	
<i>iron ps complex/b12/folic acid</i>	T1	
<i>iron/c/folic acd/mv cmb11/calc</i>	T1	
<i>iron/folic ac/vit bcomp,c/min</i>	T1	
<i>iron/folic acid/b12/c/docusate</i>	T1	
<i>iron/folic acid/c/b6/b12/zinc</i>	T1	
IROSPAN	T3	
NEONATAL FE	T3	
NUFERA	T3	
PROFERRIN-FORTE	T3	
VITAFOL	T3	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
<i>fluoride (sodium)</i>	T1	PPACA
<i>sodium fluoride 0.25 (0.55) mg</i>	T1	PPACA
<i>sodium fluoride 0.5 mg(1.1 mg)</i>	T1	PPACA
<i>sodium fluoride 0.5 mg/ml drop</i>	T1	PPACA
<i>sodium fluoride 1 mg (2.2 mg)</i>	T1	PPACA

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## List of Prescription Medications

### ELECT/CALORIC/H2O (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM REPLACEMENT (cont.)</b>		
EFFER-K 10 MEQ TABLET EFF	T3	
EFFER-K 20 MEQ TABLET EFF	T3	
<i>effe-r-k 25 meq tablet eff</i>	T1	
<i>potassium bicarbonate/cit ac</i>	T1	
<i>potassium chloride</i>	T1	
<i>potassium cl 10% (20 meq/15ml)</i>	T1	
<i>potassium cl 20 meq packet</i>	T1	
<i>potassium cl 20% (40 meq/15ml)</i>	T1	
<i>potassium cl er 10 meq capsule</i>	T1	
<i>potassium cl er 10 meq tablet</i>	T1	
<i>potassium cl er 15 meq tablet</i>	T1	
POTASSIUM CL ER 15 MEQ TABLET	T3	
<i>potassium cl er 20 meq tablet</i>	T1	
<i>potassium cl er 8 meq capsule</i>	T1	
<i>potassium cl er 8 meq tablet</i>	T1	
<i>potassium cl10%(20meq/15ml)cup</i>	T1	
<i>potassium cl10%(40meq/30ml)cup</i>	T1	
<i>potassium cl20%(40meq/15ml)cup</i>	T1	
<b>PROTEIN REPLACEMENT</b>		
AQNEURSA	T3	PA SP
<i>levocarnitine</i>	T1	
<b>ELECT/CALORIC/H2O (Urinary Tract Conditions)</b>		
<b>DIALYSIS SOLUTIONS</b>		
PRISMASOL	T3	
<b>URINARY PH MODIFIERS</b>		
<i>citric acid/sodium citrate</i>	T1	HD
K-PHOS NO.2	T3	HD
K-PHOS ORIGINAL	T3	HD
ORACIT	T3	HD
<i>potassium citrate</i>	T1	HD
<i>potassium citrate (Urocit-K)</i>	T1	HD

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# List of Prescription Medications

## ELECT/CALORIC/H2O (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>URINARY PH MODIFIERS (cont.)</b>		
<i>potassium citrate/citric acid</i>	T1	HD
RENACIDIN	T3	HD
<i>sod/pot/k cit/sod cit/cit acid</i>	T1	HD
UROCIT-K ( <i>potassium citrate</i> )	T3	HD
UROQID-ACID NO.2	T3	HD
<b>GASTROINTESTINAL (Cholesterol Medications)</b>		
<b>LIPOTROPICS</b>		
<i>icosapent ethyl (Vascepa)</i>	T1	HD
<i>omega-3 acid ethyl esters (Lovaza)</i>	T1	HD
VASCEPA ( <i>icosapent ethyl</i> )	T2	PA HD
<b>GASTROINTESTINAL (Gastrointestinal/Heartburn)</b>		
<b>AMMONIA INHIBITORS</b>		
<i>glycerol phenylbutyrate</i>	T1	SP HD
<i>lactulose</i>	T1	HD
<i>lactulose 10 gm/15 ml solution</i>	T1	
LITHOSTAT	T3	HD
OLPRUVA	T3	PA SP HD
PHEBURANE	T2	PA QL(8 BOTTLES/30 DAYS) SP HD
<i>sodium phenylbutyrate (Buphenyl)</i>	T1	SP HD
<b>ANTI-CHOLINERGICS, QUATERNARY AMMONIUM</b>		
<i>chlordiazepoxide/clidinium br (Librax)</i>	T1	
CUVPOSA ( <i>glycopyrrolate</i> )	T3	
GLYCATE	T3	
<i>glycopyrrolate 1 mg tablet (Robinul)</i>	T1	
<i>glycopyrrolate 1 mg/5 ml soln (Cuvposa)</i>	T1	
<i>glycopyrrolate 2 mg tablet (Robinul Forte)</i>	T1	
<b>ANTI-CHOLINERGICS/ANTI-SPASMODICS</b>		
<i>dicyclomine 10 mg capsule</i>	T1	
<i>dicyclomine 10 mg/5 ml soln</i>	T1	
<i>dicyclomine 20 mg tablet</i>	T1	
<b>ANTI-DIARRHEAL - G.I. CHLORIDE CHANNEL INHIBITORS</b>		
MYTESI	T3	SP

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# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-DIARRHEAL - TRYPTOPHAN HYDROXYLASE INHIBITOR</b>		
XERMELO	T3	PA SP
<b>ANTIDIARRHEAL MICROORGANISMS AGENTS</b>		
RESTORA RX	T3	
<b>ANTI-DIARRHEALS</b>		
<i>diphenoxylate hcl/atropine</i>	T1	
<i>diphenoxylate hcl/atropine (Lomotil)</i>	T1	
<i>loperamide hcl</i>	T1	
MOTOFEN	T3	
<i>opium tincture</i>	T1	PA
<b>ANTI-EMETIC, CANNABINOID-TYPE</b>		
<i>dronabinol (Marinol)</i>	T1	
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS</b>		
AKYNZEO	T3	PA QL(4 CAPS/28 DAYS)
<i>aprepitant 125 mg capsule</i>	T1	QL(4 CAPS/28 DAYS)
<i>aprepitant 125-80-80 mg pack (Emend)</i>	T1	QL(12 CAPS/28 DAYS)
<i>aprepitant 40 mg capsule</i>	T1	QL(1 CAP/28 DAYS)
<i>aprepitant 80 mg capsule (Emend)</i>	T1	QL(8 CAPS/28 DAYS)
BONJESTA	T3	
COMPAZINE ( <i>prochlorperazine maleate</i> )	T3	
COMPAZINE ( <i>prochlorperazine</i> )	T3	
<i>doxylamine succinate/vit b6 (Diclegis)</i>	T1	QL(4 TABS/DAY)
EMEND 125 MG POWDER PACKET	T3	PA QL(12 PACKS/28 DAYS)
<i>EMEND 150 MG VIAL (fosaprepitant dimeglumine)</i>	T3	
<i>fosaprepitant dimeglumine (Emend)</i>	T1	
<i>granisetron hcl</i>	T1	
<i>granisetron hcl/pf</i>	T1	
<i>ondansetron hcl</i>	T1	
<i>ondansetron hcl/pf</i>	T1	
<i>ondansetron odt 4 mg tablet</i>	T1	
<i>ondansetron odt 8 mg tablet</i>	T1	
<i>prochlorperazine (Compazine)</i>	T1	
<i>prochlorperazine maleate (Compazine)</i>	T1	
<i>promethazine hcl</i>	T1	
SANCUSO	T3	PA QL(4 PATCHES/30 DAYS)

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# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-EMETIC/ANTI-VERTIGO AGENTS (cont.)</b>		
<i>scopolamine</i> (Transderm-Scop)	T1	
TRANSDERM-SCOP ( <i>scopolamine</i> )	T3	
<i>trimethobenzamide hcl</i>	T1	
VARUBI	T3	PA QL(4 TABS/28 DAYS)
<b>ANTI-ULCER PREPARATIONS</b>		
CYTOTEC ( <i>misoprostol</i> )	T3	HD
<i>misoprostol</i> (Cytotec)	T1	HD
<i>sucralfate</i>	T1	HD
<i>sucralfate</i> (Carafate)	T1	HD
<b>ANTI-ULCER-H.PYLORI AGENTS</b>		
<i>bismuth/metronid/tetracycline</i> (Pylera)	T1	
<i>lansoprazole/amoxicilin/clarith</i>	T1	
<b>BELLADONNA ALKALOIDS</b>		
<i>hyoscyamine sulfate</i>	T1	HD
<i>hyoscyamine sulfate</i> (Levbid)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin)	T1	HD
<i>hyoscyamine sulfate</i> (Levsin-SI)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T1	HD
<i>hyoscyamine sulfate</i> (Nulev)	T3	HD
LEVSIN ( <i>hyoscyamine sulfate</i> )	T3	HD
<i>methscopolamine bromide</i>	T1	HD
NULEV ( <i>hyoscyamine sulfate</i> )	T3	HD
<i>phenobarb/hyoscy/atropine/scop</i>	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Donnatal)	T1	HD
<i>phenobarb/hyoscy/atropine/scop</i> (Phenobarbital-Belladonna)	T1	HD
PHENOBARBITAL-BELLADONNA ( <i>phenobarb/hyoscy/atropine/scop</i> )	T3	HD
SYMAX DUOTAB	T3	HD
<b>BILE SALTS</b>		
CHENODAL	T3	PA SP HD
CHOLBAM	T3	PA SP HD
CTEXLI	T3	PA SP
URSO FORTE ( <i>ursodiol</i> )	T3	HD

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# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>BILE SALTS (cont.)</b>		
<i>ursodiol 250 mg tablet</i>	T1	HD
<i>ursodiol 300 mg capsule</i>	T1	HD
<i>ursodiol 500 mg tablet (Urso Forte)</i>	T1	HD
<b>CHRONIC INFLAM. COLON DX, 5-A-SALICYLAT, RECTAL TX</b>		
<i>mesalamine 1,000 mg supp (Canasa)</i>	T1	
<i>mesalamine 4 gm/60 ml enema (Sfrowasa)</i>	T1	
<i>mesalamine 4 gm/60 ml kit (Rowasa)</i>	T1	
SFROWASA ( <i>mesalamine</i> )	T3	
<b>DRUG TX-CHRONIC INFLAM. COLON DX, 5-AMINOSALICYLAT</b>		
APRISO ( <i>mesalamine</i> )	T3	HD
<i>balsalazide disodium (Colazal)</i>	T1	HD
<i>mesalamine</i>	T1	HD
<i>mesalamine (Apriso)</i>	T1	HD
<i>mesalamine (Pentasa)</i>	T1	HD
<i>mesalamine 800 mg dr tablet (Asacol Hd)</i>	T1	HD
<i>mesalamine dr 1.2 gm tablet (Lialda)</i>	T1	HD
PENTASA 500 MG CAPSULE ( <i>mesalamine</i> )	T3	HD
<i>sulfasalazine (Azulfidine)</i>	T1	HD
<b>FARNESOID X RECEPTOR (FXR) AGONIST, BILE AC ANALOG</b>		
OCALIVA	T3	PA SP HD
<b>FECAL MICROBIOTA TRANSPLANTATION (FMT)</b>		
VOWST	T3	PA QL(12 CAPS/56 DAYS) SP
<b>GASTRIC ENZYMES</b>		
SUCRAID	T3	PA SP
<b>HEMORRHOID PREP,ANTI-INFLAM STEROID-LOCAL ANESTHET</b>		
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine (Analpram Hc)</i>	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
<b>HISTAMINE H2-RECEPTOR INHIBITORS</b>		
<i>cimetidine hcl</i>	T1	HD
<i>famotidine</i>	T1	HD

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# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IBS AGENTS, MIXED OPIOID RECEPTOR AGONISTS/ANTAGONISTS</b>		
VIBERZI	T2	HD
<b>IBS-C/CIC AGENTS, GUANYLATE CYCLASE-C AGONIST</b>		
LINZESS	T2	
TRULANCE	T2	
<b>INTEGRIN RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
ENTYVIO	T2	PA SP HD
<b>INTESTINAL MOTILITY STIMULANTS</b>		
<i>metoclopramide hcl</i>	T1	
<i>metoclopramide hcl</i> (Reglan)	T1	
<i>prucalopride succinate</i> (Motegrity)	T1	
REGLAN ( <i>metoclopramide hcl</i> )	T3	
<b>IRRITABLE BOWEL SYNDROME AGENTS, 5-HT<sub>3</sub> ANTAGONIST</b>		
<i>alosetron hcl</i> (Lotronex)	T1	SP HD
<b>LAXATIVES AND CATHARTICS</b>		
bisac/nal/nahco3/kcl/peg 3350	T1	PPACA
<i>lactulose</i>	T1	
<i>lactulose 10 gm/15 ml soln cup</i>	T1	
<i>lactulose 10 gm/15 ml solution</i>	T1	
<i>lactulose 20 gm packet</i>	T1	
<i>lactulose 20 gm/30 ml soln cup</i>	T1	
<i>lactulose 20 gm/30 ml solution</i>	T1	
<i>lubiprostone</i> (Amitiza)	T1	
<i>peg3350/sod sul/nacl/kcl/asb/c</i> (Moviprep)	T1	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i>	T1	PPACA
<i>peg3350/sod sulf,bicarb,cl/kcl</i> (Golytely)	T1	PPACA
<i>sodium chloride/nahco3/kcl/peg</i>	T1	PPACA
<i>sodium, potassium, mag sulfates</i> (Suprep)	T1	PPACA
<b>LOCAL ANORECTAL NITRATE PREPARATIONS</b>		
<i>nitroglycerin 0.4% ointment</i> (Rectiv)	T1	
RECTIV ( <i>nitroglycerin</i> )	T3	
<b>PANCREATIC ENZYMES</b>		
PANCREAZE	T2	HD
VIOKACE	T3	HD
ZENPEP	T2	HD

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# List of Prescription Medications

## GASTROINTESTINAL (Gastrointestinal/Heartburn) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>POTASSIUM-COMPETITIVE ACID BLOCKERS (PCABS)</b>		
VOQUEZNA	T3	PA QL(1 TAB/DAY)
<b>PROTON-PUMP INHIBITORS</b>		
<i>dexlansoprazole dr 30 mg cap</i>	T1	QL(2 CAPS/DAY)
<i>dexlansoprazole dr 60 mg cap</i>	T1	QL(1 CAP/DAY)
<i>esomeprazole dr 10 mg packet (Nexium)</i>	T1	QL(4 PACKS/DAY) HD
<i>esomeprazole dr 2.5 mg packet (Nexium)</i>	T1	QL(16 PACKS/DAY) HD
<i>esomeprazole dr 20 mg packet (Nexium)</i>	T1	QL(2 PACKS/DAY) HD
<i>esomeprazole dr 40 mg packet (Nexium)</i>	T1	QL(1 PACK/DAY) HD
<i>esomeprazole dr 5 mg packet (Nexium)</i>	T1	QL(8 PACKS/DAY) HD
<i>esomeprazole mag dr 20 mg cap</i>	T1	QL(2 CAPS/DAY) HD
<i>esomeprazole mag dr 40 mg cap</i>	T1	QL(1 CAP/DAY) HD
<i>esomeprazole sodium</i>	T1	
<i>lansoprazole dr 15 mg capsule</i>	T1	QL(2 CAPS/DAY) HD
<i>lansoprazole dr 15 mg odt (Prevacid)</i>	T1	QL(2 TABS/DAY) HD
<i>lansoprazole dr 30 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>lansoprazole dr 30 mg odt (Prevacid)</i>	T1	QL(1 TAB/DAY) HD
<i>omeprazole dr 10 mg capsule</i>	T1	QL(4 CAPS/DAY) HD
<i>omeprazole dr 20 mg capsule</i>	T1	QL(2 CAPS/DAY) HD
<i>omeprazole dr 40 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>omeprazole-bicarb 20-1,100 cap</i>	T1	PA QL(2 CAPS/DAY) HD
<i>omeprazole-bicarb 20-1,680 pkt</i>	T1	PA QL(2 PACKS/DAY) HD
<i>omeprazole-bicarb 40-1,100 cap</i>	T1	PA QL(1 CAP/DAY) HD
<i>omeprazole-bicarb 40-1,680 pkt</i>	T1	PA QL(1 PACK/DAY) HD
<i>pantoprazole dr 40 mg susp pkt</i>	T1	QL(1 PACK/DAY) HD
<i>pantoprazole sod dr 20 mg tab</i>	T1	QL(2 TABS/DAY) HD
<i>pantoprazole sod dr 40 mg tab</i>	T1	QL(1 TAB/DAY) HD
<i>pantoprazole sodium 40 mg vial</i>	T1	
<i>rabeprazole sodium</i>	T1	QL(1 TAB/DAY) HD
<b>RECTAL PREPARATIONS</b>		
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone acetate (Anusol-Hc)</i>	T1	
<b>SBS - GLUCAGON-LIKE PEPTIDE-2 (GLP-2) ANALOGS</b>		
GATTEX	T3	PA SP HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### GASTROINTESTINAL (Pain Relief And Inflammatory Disease)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HEMORRHOID PREP, ANTI-INFLAM STEROID-LOCAL ANESTHET</b>		
ANA-LEX	T1	
ANALPRAM HC 1% CREAM	T3	
<i>hydrocortisone/lidocaine/aloe</i>	T1	
<i>hydrocortisone/pramoxine</i>	T1	
<i>hydrocortisone/pramoxine</i> (Analpram Hc)	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
LIDOCAINE-HYDROCORTISONE	T1	
PROCORT	T3	
PROCTOFOAM-HC	T3	
<b>RECTAL/LOWER BOWEL PREP, GLUCOCORT. (NON-HEMORR)</b>		
<i>budesonide 2 mg rectal foam</i> (Uceris)	T1	QL(2 KITS/180 DAYS)
CORTENEMA ( <i>hydrocortisone</i> )	T3	
<i>hydrocortisone</i> (Cortenema)	T1	
<b>HORMONES (Hormonal Agents)</b>		
<b>ADRENAL STEROID INHIBITORS</b>		
ISTURISA	T3	PA QL (2 TABS/DAY) SP
<b>ANDROGEN/ESTROGEN PREPS FOR FEMALE SEXUAL DYSFUNC</b>		
INTRAROSA	T3	QL(30 INSERTS/30 DAYS)
<b>ANDROGENIC AGENTS</b>		
DEPO-TESTOSTERONE	T3	
DEPO-TESTOSTERONE (testosterone cypionate)	T3	
METHITEST	T1	
methyltestosterone	T1	
<i>oxandrolone</i>	T1	PA
<i>testosterone 1% (25mg/2.5g) pk</i> (Androgel)	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1% (50 mg/5 g) pk</i> (Androgel)	T1	PA QL(300 GMS/30 DAYS)
<i>testosterone 1.62% (2.5 g) pkt</i>	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1.62% gel pump</i> (Androgel)	T1	PA QL(150 GMS/30 DAYS)
<i>testosterone 1.62%(1.25 g) pkt</i>	T1	PA QL(75 GMS/30 DAYS)
<i>testosterone 10 mg gel pump</i>	T1	PA QL(120 GMS/30 DAYS)
<i>testosterone 12.5 mg/1.25 gram</i>	T1	PA QL(150 GMS/30 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANDROGENIC AGENTS (cont.)</b>		
testosterone 30 mg/1.5 ml pump	T1	PA QL(180 MLS/30 DAYS)
testosterone 50 mg/5 gram gel (Testim)	T1	PA QL(10 GMS/DAY)
testosterone 50 mg/5 gram gel (Vogelxo)	T1	PA QL(10 GMS/DAY)
TESTOSTERONE 50 MG/5 GRAM PKT	T1	PA QL(300 GMS/30 DAYS)
testosterone cypionate	T1	
testosterone cypionate (Depo-Testosterone)	T1	
testosterone enanthate	T1	
XYOSTED	T3	PA QL(2 ML/28 DAYS)
<b>ANTI-DIURETIC AND VASOPRESSOR HORMONES</b>		
desmopressin (nonrefrigerated)	T1	
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate	T1	
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
STIMATE	T3	SP
<b>ANTIDIURETIC AND VASOPRESSOR HORMONES</b>		
desmopressin 0.01% solution	T1	HD
desmopressin 10 mcg/0.1 ml spr	T1	HD
desmopressin 40 mcg/10 ml vial (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml ampul (Ddavp)	T1	SP
desmopressin ac 4 mcg/ml vial (Ddavp)	T1	SP
desmopressin acetate 0.1 mg tb (Ddavp)	T1	HD
desmopressin acetate 0.2 mg tb (Ddavp)	T1	HD
NOCTIVA	T3	PA
<b>ESTROGEN AND PROGESTIN COMBINATIONS</b>		
BIJUVA	T3	
<b>ESTROGEN/ANDROGEN COMBINATIONS</b>		
estrogen, ester/me-testosterone	T1	HD
estrogen, ester/me-testosterone (Estratest F.S.)	T1	HD

T1 – Typically Generics

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ESTROGENIC AGENTS</b>		
COMBIPATCH	T2	
DEPO-ESTRADIOL	T3	HD
<i>estradiol</i> (Climara)	T1	HD
<i>estradiol</i> (Minivelle)	T1	QL(16 PATCHES/28 DAYS) HD
<i>estradiol</i> (Vivelle-Dot)	T1	QL(16 PATCHES/28 DAYS) HD
<i>estradiol</i> 0.06% 1.25g gel pump (EstroGel)	T1	HD
<i>estradiol</i> 0.1% (0.25mg) gel pk (Divigel)	T1	HD
<i>estradiol</i> 0.1% (0.5mg) gel pkt (Divigel)	T1	HD
<i>estradiol</i> 0.1% (0.75mg) gel pk (Divigel)	T1	HD
<i>estradiol</i> 0.1% (1 mg) gel pkt (Divigel)	T1	HD
<i>estradiol</i> 0.1% (1.25mg) gel pk (Divigel)	T1	HD
<i>estradiol</i> 0.5 mg tablet	T1	HD
<i>estradiol</i> 1 mg tablet	T1	HD
<i>estradiol</i> 2 mg tablet	T1	HD
<i>estradiol valerate</i> (Delestrogen)	T1	HD
<i>estradiol/norethindrone acet</i>	T1	HD
<i>estradiol/norethindrone acet</i> (Activella)	T1	HD
<i>estrogens, conjugated</i> (Premarin)	T1	HD
EVAMIST	T3	HD
MENEST	T3	HD
MENOSTAR	T3	QL(8 PATCHES/28 DAYS) HD
<i>norethind-eth estrad</i> 0.5-2.5	T1	HD
<i>norethindrone ac/eth estradiol</i>	T1	HD
<i>norethin-eth estrad</i> 1 mg-5 mcg	T1	HD
PREMARIN ( <i>estrogens, conjugated</i> )	T2	HD
PREMPHASE	T2	HD
PREMPRO	T2	HD
<b>ESTROGEN-PROGESTIN WITH ANTI-MINERALOCORTICOID COMB</b>		
ANGELIQ	T3	HD
<b>ESTROGEN-SELECTIVE ESTROGEN RECEPTOR MOD (SERM) COMB</b>		
DUAVEE	T2	
<b>GLUCOCORTICOIDS</b>		
<i>budesonide</i>	T1	
<i>budesonide</i> (Uceris)	T1	PA QL(1 TAB/DAY)

T1 – Typically Generics

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

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## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GLUCOCORTICOIDS (cont.)</b>		
<i>cortisone acetate</i>	T1	
<i>deflazacort (Emflaza)</i>	T1	PA SP
<i>deflazacort (Emflaza)</i>	T1	PA SP HD
<i>dexamethasone</i>	T1	
<i>dexamethasone 0.5 mg tablet</i>	T1	
<i>dexamethasone 0.5 mg/5 ml elx</i>	T1	
<i>dexamethasone 0.5 mg/5 ml liq</i>	T1	
<i>dexamethasone 0.75 mg tablet</i>	T1	
<i>dexamethasone 1 mg tablet</i>	T1	
<i>dexamethasone 1.5 mg tablet</i>	T1	
<i>dexamethasone 2 mg tablet</i>	T1	
<i>dexamethasone 4 mg tablet</i>	T1	
<i>dexamethasone 6 mg tablet</i>	T1	
<i>hydrocortisone (Cortef)</i>	T1	
MEDROL	T3	
MEDROL ( <i>methylprednisolone</i> )	T3	
<i>methylprednisolone</i>	T1	
<i>methylprednisolone (Medrol)</i>	T1	
ORAPRED ODT ( <i>prednisolone sodium phosphate</i> )	T3	
<i>prednisolone</i>	T1	
<i>prednisolone sodium phosphate</i>	T1	
<i>prednisolone sodium phosphate (Orapred Odt)</i>	T1	
<i>prednisone</i>	T1	
UCERIS 9 MG ER TABLET ( <i>budesonide</i> )	T3	PA QL (1 TAB/DAY)
<b>GROWTH HORMONE RELEASING HORMONE (GHRH) AND ANALOGS</b>		
EGRIFTA SV	T3	PA SP HD
EGRIFTA WR	T3	PA SP HD
<b>GROWTH HORMONES</b>		
GENOTROPIN	T2	PA SP HD
OMNITROPE	T2	PA SP HD
SEROSTIM	T2	PA SP HD
SKYTROFA	T2	PA SP HD
<b>INSULIN-LIKE GROWTH FACTOR-I (IGF-I) HORMONES</b>		
INCRELEX	T2	PA SP HD

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

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# List of Prescription Medications

## HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
LUPRON DEPOT 11.25 MG 3MO KIT	T2	PA SP HD
LUPRON DEPOT 3.75 MG KIT	T2	PA SP HD
<b>LHRH (GNRH) ANTAGONIST, ESTROGEN AND PROGESTIN COMB</b>		
MYFEMBREE	T2	PA QL(1 TAB/DAY)
ORIAHNN	T2	PA QL(2 CAPS/DAY)
<b>LHRH (GNRH) ANTAGONIST, PITUITARY SUPPRESSANT AGENTS</b>		
<i>cetorelix acetate</i> (Cetrotide)	T1	PA SP
CETROTIDE ( <i>cetorelix acetate</i> )	T2	PA SP
<i>ganirelix acet 250 mcg/0.5 ml</i> (Ganirelix Acetate)	T1	PA SP
GANIRELIX ACET 250 MCG/0.5 ML ( <i>ganirelix acetate</i> )	T2	PA SP
<i>ganirelix acetate</i> (Ganirelix Acetate)	T1	PA SP
ORLISSA 150 MG TABLET	T2	PA QL(1 TAB/DAY)
ORLISSA 200 MG TABLET	T2	PA QL(2 TABS/DAY)
<b>LHRH (GNRH) AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY</b>		
FENSOLVI	T2	PA SP
LUPRON DEPOT-PED	T3	PA SP HD
<b>MINERALOCORTICIDS</b>		
<i>fludrocortisone acetate</i>	T1	HD
<b>OXYTOCICS</b>		
CERVIDIL	T3	
<i>methylergonovine maleate</i>	T1	
PREPIDIL	T3	
<b>PARATHYROID HORMONES</b>		
YORVIPATH	T3	PA SP
<b>PITUITARY SUPPRESSIVE AGENTS</b>		
<i>cabergoline</i>	T1	QL(16 TABS/28 DAYS) HD
CRENESSITY 25 MG CAPSULE	T3	PA QL(4 CAPS/DAY) SP
CRENESSITY 50 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 100 MG CAPSULE	T3	PA QL(2 CAPS/DAY) SP
CRENESSITY 50 MG/ML SOLUTION	T3	PA QL(8 MLS/DAY) SP
<i>danazol</i>	T1	HD
<b>PROGESTATIONAL AGENTS</b>		
CRINONE 4% GEL	T3	PA HD
<i>medroxyprogesterone 10 mg tab</i> (Provera)	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### HORMONES (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PROGESTATIONAL AGENTS (cont.)</b>		
<i>medroxyprogesterone 2.5 mg tab (Provera)</i>	T1	HD
<i>medroxyprogesterone 5 mg tab (Provera)</i>	T1	HD
<i>norethindrone acetate</i>	T1	HD
<i>progesterone 100 mg capsule (Prometrium)</i>	T1	HD
<i>progesterone 200 mg capsule (Prometrium)</i>	T1	HD
<b>SOMATOSTATIC AGENTS</b>		
<i>lanreotide 120 mg/0.5 ml syrng</i>	T1	PA SP HD
LANREOTIDE 120 MG/0.5 ML SYRNG	T3	PA SP HD
<i>octreotide acetate</i>	T1	PA SP HD
<i>octreotide acetate (Sandostatin)</i>	T1	PA SP HD
<i>octreotide acetate,mi-spheres (Sandostatin Lar Depot)</i>	T1	PA SP
SANDOSTATIN ( <i>octreotide acetate</i> )	T3	PA SP HD
SANDOSTATIN LAR DEPOT ( <i>octreotide acetate,mi-spheres</i> )	T3	PA SP
SIGNIFOR	T3	PA SP
SIGNIFOR LAR	T3	PA SP
SOMATULINE DEPOT	T2	PA SP HD
<b>VAGINAL ESTROGEN PREPARATIONS</b>		
<i>estradiol (Vagifem)</i>	T1	QL(36 TABS/28 DAYS)
<i>estradiol 0.01% cream (Estrace)</i>	T1	HD
<i>estradiol 10 mcg vaginal insrt (Vagifem)</i>	T1	QL(36 TABS/28 DAYS) HD
PREMARIN	T2	HD
<b>HORMONES (Infertility)</b>		
<b>FERTILITY STIMULATING PREPARATIONS, NON-FSH</b>		
<i>clomiphene citrate</i>	T1	
<b>FOLLICLE-STIMULATING AND LUTEINIZING HORMONES</b>		
MENOPUR	T2	PA SP
<b>FOLLICLE-STIMULATING HORMONE (FSH)</b>		
FOLLISTIM AQ	T3	PA SP
GONAL-F	T2	PA SP
GONAL-F RFF REDI-JECT	T2	PA SP
<b>HUMAN CHORIONIC GONADOTROPIN (HCG)</b>		
CHORIONIC GONADOTROPIN	T3	PA SP
NOVAREL	T2	PA SP

T1 – Typically Generics

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T2 – Typically Preferred Brands

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SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### HORMONES (Infertility) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HUMAN CHORIONIC GONADOTROPIN (HCG) (cont.)</b>		
OVIDREL	T2	PA SP
PREGNYL	T2	PA SP
<b>PREGNANCY FACILITATING/MAINTAINING AGENT, HORMONAL</b>		
CRINONE 8% GEL	T2	
ENDOMETRIN (progesterone, micronized)	T2	
progesterone 100 mg vag insert (Endometrin)	T1	

### HORMONES (Miscellaneous)

<b>LEPTIN HORMONE ANALOGS</b>		
MYALEPT	T3	PA SP HD

### HORMONES (Osteoporosis Products)

<b>BONE RESORPTION INHIBITORS</b>		
calcitonin, salmon, synthetic	T1	HD
calcitonin, salmon, synthetic (Miacalcin)	T1	HD
MIACALCIN (calcitonin, salmon, synthetic)	T3	HD

### IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease)

<b>HUMAN INTERLEUKIN 12/23 (IL-12/13) INHIBITORS, MAB</b>		
SELARSDI	T2	PA QL(1 SYRINGE/84 DAYS) SP
STELARA	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
USTEKINUMAB-TTWE	T2	PA QL(1 SYRINGE/84 DAYS) SP HD
YESINTEK	T2	PA QL(1 SYRINGE/84 DAYS) SP
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY</b>		
OMVOH 100 MG/ML PEN	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 100 MG/ML SYRINGE	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 PENS	T2	PA QL(2 PENS/28 DAYS) SP HD
OMVOH 200 MG DOSE - 2 SYRINGES	T2	PA QL(2 SYRINGES/28 DAYS) SP HD
OMVOH 200 MG/2 ML PEN	T2	PA QL SP HD
OMVOH 200 MG/2 ML SYRINGE	T2	PA QL SP HD
OMVOH 300 MG DOSE - 2 PENS	T2	PA QL(3 MLS/28 DAYS) SP HD
OMVOH 300 MG DOSE - 2 SYRINGES	T2	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI ON-BODY	T2	PA QL(1 CARTRIDGE/56 DAYS) SP HD
TREMFYA	T2	PA QL(1 SYRINGE/56 DAYS) SP HD
TREMFYA 100 MG/ML PEN	T2	PA QL(1 ML/56 DAYS) SP HD

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IL-23 RECEPTOR ANTAGONIST, MONOCLONAL ANTIBODY (cont.)</b>		
TREMFYA 200 MG/2 ML PEN	T2	PA QL(2 SYRINGE/28 DAYS) SP HD
TREMFYA ONE-PRESS	T2	PA QL(1 AUTO-INJ/56 DAYS) SP HD
TREMFYA PEN INDUCTION (2 PEN)	T2	PA QL(12 MLS/365 DAYS) SP HD
<b>INTERLEUKIN-4(IL-4) RECEPTOR ALPHA ANTAGONIST, MAB</b>		
DUPIXENT PEN	T2	PA SP HD
DUPIXENT SYRINGE	T2	PA SP HD
<b>INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS</b>		
ACTEMRA	T2	PA QL(3.6 ML/28 DAYS) SP HD
ACTEMRA ACTPEN	T2	PA QL(3.6 ML/28 DAYS) SP HD
ENSPRYNG	T3	PA SP HD
KEVZARA	T3	PA QL(2 PENS/SYRINGES/28 DAYS) SP HD
TYENNE	T2	PA QL(3.6 ML/28 DAYS) SP
TYENNE AUTOINJECTOR	T2	PA QL(3.6 ML/28 DAYS) SP
<b>INTERLEUKIN-3I(IL-3I)RECEPTOR ALPHA ANTAGONIST,MAB</b>		
NEMLUVIO	T2	PA SP HD

### IMMUNOSUPPRESSANTS (Skin Conditions)

<b>TOPICAL IMMUNOSUPPRESSIVE AGENTS</b>		
HYFTOR	T3	PA SP
<i>pimecrolimus (Elidel)</i>	T1	
<i>tacrolimus 0.03% ointment</i>	T1	
<i>tacrolimus 0.1% ointment</i>	T1	

### IMMUNOSUPPRESSANTS (Transplant Medications)

<b>IMMUNOSUPPRESSIVES</b>		
ASTAGRAF XL	T3	SP HD
<i>azathioprine 50 mg tablet (Imuran)</i>	T1	SP HD
<i>cyclosporine 100 mg capsule (Sandimmune)</i>	T1	SP HD
<i>cyclosporine 25 mg capsule (Sandimmune)</i>	T1	SP HD
<i>cyclosporine, modified</i>	T1	SP HD
<i>cyclosporine, modified (Neoral)</i>	T1	SP HD
ENVARUSUS XR	T3	SP HD
<i>everolimus 0.25 mg tablet (Zortress)</i>	T1	SP HD
<i>everolimus 0.5 mg tablet (Zortress)</i>	T1	SP HD

T1 – Typically Generics

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### IMMUNOSUPPRESSANTS (Transplant Medications) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IMMUNOSUPPRESSIVES (cont.)</b>		
<i>everolimus 0.75 mg tablet (Zortress)</i>	T1	SP HD
<i>everolimus 1 mg tablet (Zortress)</i>	T1	SP HD
LUPKYNIS	T3	PA QL(6 CAPS/DAY) SP
<i>mycophenolate mofetil (Cellcept)</i>	T1	SP HD
<i>mycophenolate sodium (Myfortic)</i>	T1	SP HD
PROGRAF 0.2 MG GRANULE PACKET	T3	SP HD
PROGRAF 1 MG GRANULE PACKET	T3	SP HD
SANDIMMUNE 100 MG/ML SOLN	T2	SP HD
<i>sirolimus</i>	T1	SP HD
<i>sirolimus (Rapamune)</i>	T1	SP HD
<i>tacrolimus 0.5 mg capsule (ir) (Prograf)</i>	T1	SP HD
<i>tacrolimus 1 mg capsule (ir) (Prograf)</i>	T1	SP HD
<i>tacrolimus 5 mg capsule (ir) (Prograf)</i>	T1	SP HD
ZORTRESS ( <i>everolimus</i> )	T3	SP HD

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes)

<b>DIABETIC SUPPLIES</b>		
ZTEK	T1	
ACCU-CHEK	T1	
ACCU-CHEK FASTCLIX LANCING DEV	T1	
ACCU-CHEK GUIDE CONTROL SOLN	T1	
ACCU-CHEK SMARTVIEW CONTRL SOL	T1	
ACCU-CHEK SOFTCLIX	T1	
ACCUTREND GLUCOSE CONTROL	T1	
ADJUSTABLE LANCING DEVICE	T1	
ADVANCED LANCING DEVICE	T1	
ADVOCATE CONTROL SOLUTION	T1	
ADVOCATE LANCING DEVICE	T1	
ADVOCATE RAPID-SAFE LANCING DV	T1	
ADVOCATE REDI-CODE+ CTRL SOLN	T1	
AGAMATRIX CONTROL	T1	
AGAMATRIX CONTROL SOLUTION	T1	
ALKALINE BATTERIES	T1	

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HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
ALTERNATE SITE LANCING DEVICE	T1	
AQUA LANCE LANCING DEVICE	T1	
ASSURE 4 CONTROL SOLUTION	T1	
ASSURE CONTROL SOLUTION	T1	
ASSURE DOSE	T1	
ASSURE PRISM	T1	
AT HOME A1C	T1	
AUTOJECT 2	T1	
AUTO-LANCET MINI	T1	
AUTOLET IMPRESSION	T1	
AUTOLET LANCING DEVICE	T1	
AUTOLET LITE	T1	
AUTOLET PLUS	T1	
AUTOPEN	T1	
BLOOD GLUCOSE CONTROL	T1	
BLOOD-GLUCOSE CONTROL	T1	
BREEZE 2	T1	
CAREONE	T1	
CARESENS	T1	
CARESENS S CONTROL SOLUTION	T1	
CARETOUCH CONTROL SOLUTION	T1	
CARETOUCH LANCING DEVICE	T1	
CEQR SIMPLICITY	T2	
CEQR SIMPLICITY INSERTER	T2	
CHEMSTRIP BG DIARY	T1	
CHOSEN LANCING DEVICE	T1	
CLEVER CHOICE CONTROL SOLUTION	T1	
CONTOUR	T1	
CONTOUR NEXT CONTROL SOLUTION	T1	
CONTROL SOLUTION	T1	
COOL CONTROL SOLUTION	T1	
DEXCOM G6 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
DEXCOM G6 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G6 TRANSMITTER	T2	PA QL(1 UNIT/90 DAYS)
DEXCOM G7 15 DAY SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DEXCOM G7 RECEIVER	T2	PA QL(1 UNIT/365 DAYS)
DEXCOM G7 SENSOR	T2	PA QL(3 SENSORS/30 DAYS)
DIATRUE	T1	
DROPLET GENTEEL LANCING DEVICE	T1	
DROPLET LANCING DEVICE	T1	
EASY MINI EJECT LANCING DEVICE	T1	
EASY PLUS II CONTROL SOLN HIGH	T1	
EASY PLUS II CONTROL SOLN LOW	T1	
EASY STEP CONTROL SOLUTION	T1	
EASY TALK CONTROL SOLN LOW	T1	
EASY TALK HIGH CONTROL SOLN	T1	
EASY TALK PLUS II HIGH CONTROL	T1	
EASY TALK PLUS II LOW CTRL SLN	T1	
EASY TOUCH BLULINK CTRL SOLN	T1	
EASY TOUCH CONTROL SOLUTION	T1	
EASY TOUCH LANCING DEVICE	T1	
EASY TRAK CONTROL SOLN HIGH	T1	
EASY TRAK CONTROL SOLN LOW	T1	
EASY TRAK II CONTROL SOLUTION	T1	
EASYGLUCO PLUS CONTROL NORMAL	T1	
EASYMAX 15 LEVEL 2 SOLUTION	T1	
EASYMAX NORMAL CONTROL SOLN	T1	
ELEMENT COMPACT CONTROL SOLN	T1	
ELEMENT CONTROL SOLUTION	T1	
EMBRACE EVO LEVEL 1 CTRL SOLN	T1	
EMBRACE GLUC CONTROL SOLN HIGH	T1	
EMBRACE GLUCOSE CONTROL SOLN	T1	
EMBRACE LANCING DEVICE	T1	
EMBRACE PRO	T1	
EMBRACE TALK CONTROL SOLUTION	T1	
ENLITE SERTER	T1	

T1 – Typically Generics

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AGE – Age Requirement

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
EVENCARE G2 CONTROL SOLUTION	T1	
EVENCARE G3 CONTROL SOLUTION	T1	
EVOLUTION CONTROL SOLUTION	T1	
FONDCIRCLE CONTROL SOLUTION	T1	
FONDCIRCLE LANCING DEVICE	T1	
FORA 6 CONNECT MULTIFUNCTN MTR	T3	
FORA CONTROL SOLUTION	T1	
FORA GTEL MULTIFUNCTN MONITOR	T1	
FORA KETONE CONTROL SOLUTION	T3	
FORA LANCING DEVICE	T1	
FORA TN'G ADVANCE PRO MONITOR	T3	
FORA TN'GO ADV MOBILE MULT MTR	T3	
FORA TN'GO ADVANCE MULTIFN MTR	T3	
FORACARE GDH	T1	
FORTISCARE	T1	
FREESTYLE CONTROL SOLUTION	T1	
FREESTYLE LIBRE 14 DAY READER	T2	
FREESTYLE LIBRE 14 DAY SENSOR	T2	
FREESTYLE LIBRE 2 PLUS SENSOR	T2	
FREESTYLE LIBRE 2 READER	T2	
FREESTYLE LIBRE 2 SENSOR	T2	
FREESTYLE LIBRE 3 PLUS SENSOR	T2	
FREESTYLE LIBRE 3 READER	T2	
FREESTYLE LIBRE 3 SENSOR	T2	
GE100 CONTROL SOLUTION NORMAL	T1	
GENTEEL VACUUM LANCING DEVICE	T1	
GLUCOCARD 01 CONTROL	T1	
GLUCOCARD EXPRESSION CNTRL SLN	T1	
GLUCOCARD SHINE CONTROL SOLN	T1	
GLUCOCOM AUTOLINK	T1	
GLUCOCOM CONTROL SOLUTION	T1	
GLUCOSE CONTROL	T1	
GLUCOSE CONTROL SOLUTION	T1	
GOJJI GLUCOSE CONTROL SOLUTION	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
GOJJI KETONE CONTROL SOLUTION	T3	
GOJJI LANCING DEVICE	T1	
GOJJI MULTI-FUNCTIONAL METER	T3	
GUARDIAN RT CHARGER	T1	
GUARDIAN TEST PLUG	T1	
GUARDIAN TRANSMITTER TAPE	T1	
HEALTHPRO GLUCOSE CONTROL SOLN	T1	
HEALTHY ACCENTS AUTOLET	T1	
HYPOLANCE	T1	
IHEALTH CONTROL SOLN LEVEL 2	T1	
INCONTROL LANCING DEVICE	T1	
INFINITY CONTROL SOLUTION	T1	
INFINITY VOICE CONTROL SOLN	T1	
INPEN (FOR HUMALOG)	T1	
INPEN (FOR NOVLOG OR FIASP)	T1	
INSUL-CAP	T1	
INSUL-EZE	T1	
LANCING DEVICE	T1	
LANCING SYSTEM	T1	
LANZO	T1	
LITE TOUCH LANCING PEN	T1	
MEDISENSE	T1	
MEDISENSE GLUCOSE KETONE	T1	
MEDISENSE GLUCOSE KETONE CONTR	T1	
MEDTRONIC REMOTE CONTROL	T1	
MICRODOT HIGH-LOW CONTROL SOL	T1	
MICRODOT NORMAL CONTROL SOLUT	T1	
MICROLET 2	T1	
MICROLET NEXT LANCING DEVICE	T1	
MINI LANCING DEVICE	T1	
MINIMED QUICK-SERTER	T1	
MULTI-LANCET	T1	
MYGLUCOHEALTH CONTROL SOLUTION	T1	
NOVA MAX PLUS GLUC-KETON METER	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
NOVAMAX PLUS GLU-KET	T1	
NOVOPEN ECHO	T1	
OMNIPOD 5 (G6/LIBRE 2 PLUS)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD 5 G6-G7 PODS (GEN 5)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PDM KIT(GEN 3)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD CLASSIC PODS (GEN 3)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD DASH INTRO KIT (GEN 4)	T2	QL(1 UNIT/365 DAYS)
OMNIPOD DASH PODS (GEN 4)	T2	QL(30 CRTGS/30 DAYS)
OMNIPOD GO PODS	T2	QL(30 CRTGS/30 DAYS)
ON CALL EXPRESS CONTROL SOLN	T1	
ON CALL LANCING DEVICE	T1	
ON CALL PLUS CONTROL	T1	
ON CALL PLUS LANCING DEVICE	T1	
ON CALL VIVID CONTROL	T1	
ONETOUCH DELICA PLUS LANC DEV	T1	
ONETOUCH ULTRA CONTROL SOLN	T1	
ONETOUCH VERIO HIGH CNTRL SOLN	T1	
ONETOUCH VERIO MID CNTRL SOLN	T1	
OPTUMRX GLUCOSE CONTROL SOLN	T1	
OVAL TAPE	T1	
PIP GLUCOSE CONTROL SOLUTION	T1	
PRECISION XTRA KETONE-GLUCOSE	T3	
PRODIGY CONTROL SOLUTION	T1	
PRODIGY LANCING DEVICE	T1	
REFUAH PLUS GLUCOSE CONTROL	T1	
RELIAMED MINI LANCING DEVICE	T1	
RIGHTEST CONTROL SOLUTION	T1	
RIGHTEST GD500	T1	
SAFE-CLIP	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DIABETIC SUPPLIES (cont.)</b>		
SIL-SERTER	T1	
SMARTDIABETES VANTAGE	T1	
SMARTEST	T1	
SOLUS V2 CONTROL SOLUTION	T1	
SOLUS V2 LANCING DEVICE	T1	
SURE COMFORT LANCING PEN	T1	
SUREFLEX	T1	
SURE-PEN	T1	
SURE-TEST EASYPLUS MINI SOLN	T1	
TELCARE CONTROL SOLUTION	T1	
TRUE METRIX	T1	
TRUECONTROL	T1	
TRUEDRAW	T1	
TWIST REFILL KT(CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIST RFL(INFUS-CSST-NDL-SYR)	T2	QL(30 KITS/30 DAYS)
TWIST STARTER KIT	T2	QL(1 KIT/365 DAYS)
ULTI-LANCE	T1	
ULTRATRAK CONTROL SOL NORMAL	T1	
ULTRATRAK CONTROL SOLUTION	T1	
ULTRATRAK ULTIMATE CNTRL SOLN	T1	
UNISTIK 2	T1	
UNISTRIP	T1	
V-GO 20	T2	
V-GO 30	T2	
V-GO 40	T2	
VIVAGUARD INO CONTROL SOLUTION	T1	
VIVAGUARD LANCING DEVICE	T1	
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I)</b>		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULT THIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILANCE TL	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL 1 LANCET	T1	
TOPCARE UNIVERSAL 1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	
ULTRA-THIN II 30G LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	

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# List of Prescription Medications

## MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT,MISC(GROUP I) (cont.)</b>		
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
<b>NEEDLES/NEEDLELESS DEVICES</b>		
AUTOSHIELD DUO PEN NEEDLE	T1	
BLUNT NEEDLE	T1	
CAREPOINT PRECISION NEEDLE	T1	
CARETOUCH HYPODERMIC NEEDLE	T1	
DROPSAFE SICURA SAFETY NEEDLE	T1	
EASY TOUCH FLIPLock NEEDLE	T1	
EASY TOUCH FLIPLock NEEDLES	T1	
EASY TOUCH HYPODERMIC NEEDLE	T1	
EASYPPOINT NEEDLE	T1	
ECLIPSE NEEDLE	T1	
EXEL HUBER NEEDLE	T1	
EXEL HYPODERMIC NEEDLE	T1	
EXEL MTI DRAWING NEEDLE	T1	
FILTER ASPIRATOR NEEDLE	T1	
FILTER NEEDLE	T1	
FLOW-EZE	T1	
HYPODERMIC NEEDLE	T1	
INTEGRA NEEDLE	T1	
INTEGRA PRECISIONGLIDE NEEDLE	T1	
LIFESHIELD BLUNT CANNULA	T1	
MONOJECT BLOOD COLLECTION	T1	
MONOJECT FILTER NEEDLE	T1	
NANO 2ND GEN PEN NEEDLE	T1	
NANO PEN NEEDLE	T1	
NEEDLE	T1	
NEEDLES	T1	
<i>needles,safety huber,disposabl</i>	T1	
NOKOR ADMIX NEEDLE	T1	
NOKOR NEEDLE	T1	

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>NEEDLES/NEEDLELESS DEVICES (cont.)</b>		
PERFECT POINT SAFETY NEEDLE	T1	
PHASEAL PROTECTOR	T1	
POLY HUB NEEDLE	T1	
PRECISIONGLIDE	T1	
PRECISIONGLIDE NEEDLE	T1	
REGULAR BEVEL NEEDLES	T1	
SAFETYGLIDE NEEDLE	T1	
SHORT BEVEL NEEDLES	T1	
SPECIALTY USE NEEDLES	T1	
TERUMO SURGUARD2	T1	
THIN WALL NEEDLES	T1	
TRANSFER NEEDLE	T1	
ULTRA-FINE MICRO PEN NEEDLE	T1	
ULTRA-FINE MINI PEN NEEDLE	T1	
ULTRA-FINE NANO PEN NEEDLE	T1	
ULTRA-FINE ORIGINAL PEN NEEDLE	T1	
ULTRA-FINE PEN NEEDLE	T1	
ULTRA-FINE SHORT PEN NEEDLE	T1	
YALE NEEDLES	T1	
<b>SYRINGES AND ACCESSORIES</b>		
BD INS SYR 0.3 ML 8MMX31G(1/2)	T1	
BD INS SYR UF 0.3ML 12.7MMX30G	T1	
BD INS SYR UF 0.5ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 12.7MMX30G	T1	
BD INS SYRN UF 1 ML 30G 12.7MM	T1	
BD INS SYRNG 0.3 ML 29GX12.7MM	T1	
BD INS SYRNG 0.5 ML 29GX12.7MM	T1	
BD INS SYRNG UF 0.3 ML 8MMX31G	T1	
BD INS SYRNG UF 0.5 ML 8MMX31G	T1	
BD INSULIN SYR 0.5 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 27GX12.7MM	T1	
BD INSULIN SYR 1 ML 27GX5/8"	T1	
BD INSULIN SYR 1 ML 28GX1/2"	T1	
BD INSULIN SYR 1 ML 29GX12.7MM	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Diabetes) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SYRINGES AND ACCESSORIES (cont.)</b>		
BD INSULIN SYR UF 1 ML 8MMX31G	T1	
ECLIPSE SYRINGE	T1	
INSULIN SYR 0.5 ML 28G 12.7MM	T1	
INSULIN SYRINGE 1 ML 27G 16MM	T1	
BD INSULIN SYRINGE 1 ML	T1	
INSULIN SYRINGE 1ML 28G 12.7MM	T1	
INSULIN SYRINGE U-500	T1	
MINIMED RESERVOIR	T1	
PARADIGM	T1	
SAFETYGLIDE INSULIN SYRINGE	T1	
SAFETYGLIDE SYRINGE	T1	
ULTRA-FINE INSULIN SYRINGE	T1	
VEO INSULIN SYRINGE	T1	

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous)

<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I)</b>		
1ST TIER UNILET COMFORTOUCH	T1	
2-IN-1 LANCET DEVICE	T1	
ACCU-CHEK FASTCLIX LANCET DRUM	T1	
ACCU-CHEK SAFE-T-PRO	T1	
ACCU-CHEK SAFE-T-PRO PLUS	T1	
ACCU-CHEK SOFTCLIX	T1	
ACTI-LANCE	T1	
ADVANCED TRAVEL LANCETS	T1	
ADVOCATE LANCET	T1	
ADVOCATE LANCETS	T1	
ADVOCATE SAFETY LANCET	T1	
AGAMATRIX ULTRA-THIN LANCET	T1	
ALTERNATE SITE LANCETS	T1	
ASSURE HAEMOLANCE PLUS	T1	
ASSURE LANCE	T1	
ASSURE LANCE PLUS	T1	
BD MICROTAINER LANCETS	T1	
BLOOD LANCETS	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
BULLSEYE MINI SAFETY LANCETS	T1	
BUTTERFLY TOUCH LANCET	T1	
CAREONE	T1	
CARESENS LANCET	T1	
CARETOUCH SAFETY LANCETS	T1	
CARETOUCH TWIST LANCET	T1	
CHOSEN LANCET	T1	
CHOSEN SAFETY LANCET	T1	
CLEVER CHEK LANCETS	T1	
COAGUCHEK	T1	
COLOR LANCETS	T1	
COMFORT EZ	T1	
COMFORT LANCETS	T1	
COMFORT TOUCH PLUS SAFETY LANC	T1	
COMFORT TOUCH ULTHIN LANCET	T1	
DROPLET LANCETS	T1	
DROPSAFE ACTI-LANCE	T1	
EASY COMFORT LANCETS	T1	
EASY TOUCH PULL-TOP 26G LANCET	T1	
EASY TOUCH PULL-TOP 28G LANCET	T1	
EASY TOUCH PULL-TOP 30G LANCET	T1	
EASY TOUCH PULL-TOP 32G LANCET	T1	
EASY TOUCH SAFETY 21G LANCETS	T1	
EASY TOUCH SAFETY 23G LANCETS	T1	
EASY TOUCH SAFETY 26G LANCETS	T1	
EASY TOUCH SAFETY 28G LANCETS	T1	
EASY TOUCH SAFETY 30G LANCETS	T1	
EASY TOUCH SAFETY 32G LANCETS	T1	
EASY TOUCH TWIST 26G LANCETS	T1	
EASY TOUCH TWIST 28G LANCETS	T1	
EASY TOUCH TWIST 30G LANCETS	T1	
EASY TOUCH TWIST 32G LANCETS	T1	
EASY TOUCH TWIST 33G LANCETS	T1	

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
EASY TWIST & CAP LANCETS	T1	
EMBRACE 30G LANCETS	T1	
EMBRACE SAFETY LANCET	T1	
EZ SMART LANCETS	T1	
EZ-LETS	T1	
FIFTY50 SAFETY SEAL LANCETS	T1	
FINGERSTIX	T1	
FONDCIRCLE LANCET	T1	
FORA LANCETS	T1	
FORA V10-V12-D10-D20 STRP-LNCT	T1	
FORACARE LANCETS	T1	
FREESTYLE LANCETS	T1	
FREESTYLE UNISTIK 2	T1	
GLUCOCOM	T1	
GLUCOCOM LANCETS	T1	
GOJJI LANCET-GLUCOSE TEST STRP	T1	
GOJJI LANCETS	T1	
HEALTHY ACCENTS UNILET LANCET	T1	
INCONTROL SUPER THIN LANCETS	T1	
INCONTROL ULTRA THIN LANCETS	T1	
INJECT EASE LANCETS	T1	
INVACARE LANCETS	T1	
<i>lancets</i>	T1	
LANCETS	T1	
LITE TOUCH 28G LANCETS	T1	
LITE TOUCH 30G LANCETS	T1	
LITE TOUCH 33G LANCETS	T1	
MEDISENSE THIN LANCETS	T1	
MEDLANCE PLUS	T1	
MEDLANCE PLUS SPECIAL BLADE	T1	
MICRO THIN LANCET	T1	
MICRO THIN LANCETS	T1	
MICROLET	T1	

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
MICROTAINER LANCETS	T1	
MOBILE LANCETS	T1	
MONOLET LANCETS	T1	
MONOLET THIN LANCETS	T1	
MYGLUCOHEALTH LANCETS	T1	
NOVA SAFETY LANCETS	T1	
NOVA SUREFLEX	T1	
ON CALL LANCET	T1	
ON CALL PLUS LANCET	T1	
ONETOUCH DELICA PLUS LANCET	T1	
ONETOUCH DELICA SAFETY LANCET	T1	
ONETOUCH LANCETS	T1	
ONETOUCH SURESOFT	T1	
ONETOUCH ULTRASOFT 2 LANCET	T1	
ON-THE-GO	T1	
PERFECT POINT SAFETY LANCETS	T1	
PIP LANCET	T1	
POGO AUTOMATIC TEST CARTRIDGE	T1	
PRESSURE ACTIVATED LANCETS	T1	
PRO COMFORT LANCET	T1	
PRO COMFORT LANCETS	T1	
PRO COMFORT SAFETY LANCET	T1	
PRODIGY LANCETS	T1	
PRODIGY TWIST TOP LANCET	T1	
PURE COMFORT LANCETS	T1	
PURE COMFORT SAFETY LANCETS	T1	
PUSH BUTTON SAFETY LANCETS	T1	
READYLANCE SAFETY LANCETS	T1	
RELIAMED	T1	
RELIAMED SAFETY SEAL LANCETS	T1	
RIGHTEST GL300 LANCETS	T1	
SAFETY LANCETS	T1	
SAFETY SEAL LANCETS	T1	

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## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
SAFETY-LET	T1	
SINGLE-LET	T1	
SMART SENSE	T1	
SMART SENSE LANCETS	T1	
SMARTEST LANCET	T1	
SOLUS V2	T1	
SOLUS V2 LANCETS	T1	
STERILE LANCETS	T1	
SUPER THIN LANCETS	T1	
SURE COMFORT LANCETS	T1	
SURE-LANCE	T1	
SURE-TOUCH	T1	
TECHLITE LANCETS	T1	
TELCARE ULTRA THIN 30G LANCETS	T1	
THIN LANCETS	T1	
TOPCARE UNIVERSAL1 LANCET	T1	
TOPCARE UNIVERSAL1 THIN LANCET	T1	
TRUE COMFORT LANCET	T1	
TRUE COMFORT SAFETY LANCET	T1	
TRUEPLUS LANCET	T1	
TRUEPLUS LANCETS	T1	
TWIST LANCETS	T1	
TWIST TOP LANCET	T1	
ULTILET BASIC	T1	
ULTILET CLASSIC	T1	
ULTILET LANCETS	T1	
ULTILET SAFETY	T1	
ULTRA THIN LANCET	T1	
ULTRA THIN LANCETS	T1	
ULTRA THIN PLUS LANCETS	T1	
ULTRA-CARE LANCETS	T1	
ULTRALANCE	T1	
ULTRA-THIN II 28G LANCETS	T1	

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DURABLE MEDICAL EQUIPMENT, MISC (GROUP I) (cont.)</b>		
ULTRA-THIN II 30G LANCETS	T1	
ULTRATLC LANCETS	T1	
UNILET COMFORTOUCH	T1	
UNILET EXCELITE	T1	
UNILET EXCELITE II	T1	
UNILET GP LANCET	T1	
UNILET LANCET	T1	
UNILET LANCETS	T1	
UNISTIK 2 COMFORT	T1	
UNISTIK 2 EXTRA	T1	
UNISTIK 2 NORMAL	T1	
UNISTIK 3	T1	
UNISTIK 3 COMFORT	T1	
UNISTIK 3 DUAL	T1	
UNISTIK 3 EXTRA	T1	
UNISTIK 3 NORMAL	T1	
UNISTIK COMFORT	T1	
UNISTIK CZT	T1	
UNISTIK EXTRA	T1	
UNISTIK NORMAL	T1	
UNISTIK PRO	T1	
UNISTIK SAFETY	T1	
UNISTIK TOUCH	T1	
UNIVERSAL 1	T1	
VERIFINE SAFETY LANCET MINI	T1	
VERIFINE UNIVERSAL LANCET	T1	
VIVAGUARD LANCET	T1	
VIVAGUARD SAFETY LANCET	T1	
<b>MEDICAL SUPPLIES, MISCELLANEOUS</b>		
ALCOH-GLOVE	T1	
ALCOH-WIPE	T1	
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT</b>		
ACE AEROSOL CLOUD ENHANCER	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MECHANICAL VENT	T2	QL(1 SPACER/365 DAYS)

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

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T2 – Typically Preferred Brands

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)</b>		
AEROCHAMBER MINI	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER MV	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER PLUS FLOW-VU	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER Z-STAT PLUS	T2	QL(1 SPACER/365 DAYS)
AEROCHAMBER2GO	T2	QL(1 SPACER/365 DAYS)
AEROTRACH PLUS	T2	QL(1 SPACER/365 DAYS)
AEROVENT PLUS	T2	QL(1 SPACER/365 DAYS)
BREATHERITE	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-ADULT MASK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-INFANT MASK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-LG CHLD MSK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-NEONATE MSK	T2	QL(1 SPACER/365 DAYS)
BREATHERITE SPACER-SM CHLD MSK	T2	QL(1 SPACER/365 DAYS)
BREATHRITE	T2	QL(1 SPACER/365 DAYS)
CLEVER CHOICE HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
COMFORTSEAL	T2	QL(1 UNIT/365 DAYS)
COMPACT SPACE CHAMBER	T2	QL(1 SPACER/365 DAYS)
EASIVENT HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
EASIVENT MASK-LARGE	T2	QL(1 UNIT/365 DAYS)
EASIVENT MASK-MEDIUM	T2	QL(1 UNIT/365 DAYS)
EASIVENT MASK-SMALL	T2	QL(1 UNIT/365 DAYS)
FLEXICHAMBER	T2	QL(1 SPACER/365 DAYS)
FLEXICHAMBER MASK	T2	QL(1 UNIT/365 DAYS)
LITEAIRE	T2	QL(1 SPACER/365 DAYS)
LITETOUCH	T2	QL(1 UNIT/365 DAYS)
MICROCHAMBER	T2	QL(1 SPACER/365 DAYS)
MICROSPACER	T2	QL(1 SPACER/365 DAYS)
MOUTHPIECE	T2	
ONE WAY MOUTHPIECE	T2	
OPTICHAMBER	T2	QL(1 UNIT/365 DAYS)
OPTICHAMBER DIAMOND	T2	QL(1 SPACER/365 DAYS)
PANDA MASK	T2	
PEDIATRIC MASK	T2	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MISCELLANEOUS MEDICAL SUPPLIES, DEVICES, NON-DRUG (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>RESPIRATORY AIDS, DEVICES, EQUIPMENT (cont.)</b>		
PEDIATRIC PANDA MASK	T2	
POCKET CHAMBER	T2	QL(1 SPACER/365 DAYS)
PRIMEAIRE	T2	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-ADULT MASK	T3	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-CHILD MASK	T3	QL(1 SPACER/365 DAYS)
PRO COMFORT SPACER-INFANT MASK	T3	
PROCARE SPACER WITH ADULT MASK	T2	QL(1 SPACER/365 DAYS)
PROCARE SPACER WITH CHILD MASK	T2	QL(1 SPACER/365 DAYS)
PROCHAMBER	T2	QL(1 SPACER/365 DAYS)
PURE COMFORT SPACER WITH MASK	T2	QL(1 SPACER/365 DAYS)
RITEFLO	T2	QL(1 SPACER/365 DAYS)
SIDESTREAM PEDIATRIC	T2	
SILICONE MASK-INFANT	T2	QL(1 UNIT/365 DAYS)
SILICONE MASK-PEDIATRIC	T2	
SPACE CHAMBER	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-LARGE MASK	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-MEDIUM MASK	T2	QL(1 SPACER/365 DAYS)
SPACE CHAMBER-SMALL MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX ADULT MASK	T2	
VORTEX HOLDING CHAMBER	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC FROG MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC LADYBUG MASK	T2	QL(1 SPACER/365 DAYS)
VORTEX VHC PEDIATRIC MASK	T2	QL(1 SPACER/365 DAYS)

### MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease)

<b>SKELETAL MUSCLE RELAX. TOP IRRITANT COUNTER-IRRIT</b>		
COMFORT PAC-CYCLOBENZAPRINE	T3	
COMFORT PAC-TIZANIDINE	T3	
<b>SKELETAL MUSCLE RELAXANTS</b>		
<i>baclofen 10 mg tablet</i>	T1	HD
<i>baclofen 10 mg/5 ml solution</i>	T1	HD
<i>baclofen 20 mg tablet</i>	T1	HD
<i>baclofen 5 mg tablet</i>	T1	HD
<i>baclofen 5 mg/5 ml solution</i>	T1	HD

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### MUSCLE RELAXANTS (Pain Relief And Inflammatory Disease) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SKELETAL MUSCLE RELAXANTS (cont.)</b>		
<i>carisoprodol (Soma)</i>	T1	
<i>carisoprodol/aspirin</i>	T1	
<i>chlorzoxazone 500 mg tablet</i>	T3	
<i>cyclobenzaprine hcl</i>	T1	
<i>cyclobenzaprine hcl (Fexmid)</i>	T1	
DANTRIUM ( <i>dantrolene sodium</i> )	T3	
<i>dantrolene sodium</i>	T1	
<i>dantrolene sodium (Dantrium)</i>	T1	
FEXMID ( <i>cyclobenzaprine hcl</i> )	T1	
<i>metaxalone 400 mg tablet</i>	T1	
<i>metaxalone 800 mg tablet</i>	T1	
<i>methocarbamol</i>	T3	
<i>methocarbamol 1,000 mg tablet</i>	T3	
<i>methocarbamol 500 mg tablet</i>	T3	
<i>methocarbamol 750 mg tablet</i>	T1	
<i>orphenadrine citrate</i>	T1	
<i>tizanidine hcl 2 mg tablet</i>	T1	
<i>tizanidine hcl 4 mg tablet (Zanaflex)</i>	T1	
ZANAFLEX	T3	
ZANAFLEX ( <i>tizanidine hcl</i> )	T3	
<b>PRE-NATAL VITAMINS (Nutritional/Dietary)</b>		
<b>PRENATAL VITAMIN PREPARATIONS</b>		
BAL-CARE DHA ESSENTIAL	T3	
CITRANATAL 90 DHA	T3	
CITRANATAL ASSURE	T3	
CITRANATAL DHA	T3	
CITRANATAL HARMONY	T3	
CITRANATAL RX	T3	
DERMACINRX PRETRATE	T3	
DUET DHA BALANCED	T3	
KOSHER PRENATAL PLUS IRON	T3	
MARNATAL-F	T3	
<i>mynatal capsule</i>	T3	

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CSL – Oral cancer medication subject to cost-share limits

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ST – Step Therapy

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## List of Prescription Medications

### PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PRENATAL VITAMIN PREPARATIONS (cont.)</b>		
<i>mynatal ultracaplet</i>	T1	
NATACHEW	T3	
NEONATAL COMPLETE	T3	
NEONATAL PLUS	T3	
NEONATAL-DHA	T3	
NESTABS	T2	
NESTABS ABC	T2	
NESTABS DHA	T2	
OB COMPLETE ONE	T2	
OB COMPLETE PETITE	T2	
OB COMPLETE PREMIER	T2	
OB COMPLETE WITH DHA	T2	
OBSTETRIX EC	T3	
OBTREX DHA	T3	
<i>pnv 11/iron fum/folic acid/om3</i>	T1	
<i>pnv 119/iron fum/folic acid</i>	T1	
<i>pnv 66/iron/folic/docusate/dha</i>	T1	
<i>pnv 69/iron/folic/docusate/dha</i>	T1	
<i>pnv 80/iron fum/folic/dss/dha</i>	T1	
<i>pnv no. 118/iron fumarate/fa</i>	T1	
<i>pnv no. 154/iron fum/folic acid</i>	T1	
<i>pnv no. 52/iron/fa/omega-3/dha</i>	T1	
<i>pnv, calcium 72/iron, carb/folic</i>	T1	
<i>pnv, calcium 72/iron/folic acid</i>	T1	
<i>pnv19/iron bg,s.p/folic ac/om3</i>	T1	
<i>pnv81/iron ps,edta/folic/omeg3</i>	T1	
PRENATA	T3	
<i>prenatal 105/iron/folic ac/dha</i>	T1	
<i>prenatal 12/iron/folic/dss/om3</i>	T1	
PRENATAL 19	T1	
<i>prenatal 53/iron/folic ac/omg3</i>	T1	
<i>prenatal 54/iron/folic ac/omg3</i>	T1	
<i>prenatal 71/iron/folic ac/dha</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PRENATAL VITAMIN PREPARATIONS (cont.)</b>		
<i>prenatal 93/iron/folate 9/dha</i>	T1	
<i>prenatal no.42/folic acid (Vitamedmd Redicew Rx)</i>	T3	
PRENATAL PLUS VITAMIN-MINERAL	T2	
PRENATAL PLUS-DHA	T1	
<i>prenatal vit 27,calc/iron/fa</i>	T1	
<i>prenatal vit 55/iron/folic/om3</i>	T1	
<i>prenatal vit,cal 73/iron/folic</i>	T3	
<i>prenatal vit,cal 76/iron/folic</i>	T3	
<i>prenatal vit,cal 78/iron/folic</i>	T3	
<i>prenatal vit/iron fum/folic ac</i>	T1	
<i>prenatal vits 86/iron/folic ac</i>	T1	
<i>prenatal,calc 40/iron/folate 1</i>	T1	
PRENATE ENHANCE	T3	
PRENATE RESTORE	T3	
PRIMACARE	T3	
PROVIDA OB	T3	
SELECT-OB	T3	
SELECT-OB ( <i>prenatal vit 128/iron/folic ac</i> )	T3	
SELECT-OB + DHA	T3	
THRIVITE RX	T1	
TRICARE	T3	
TRISTART DHA	T3	
VITAFOL FE PLUS	T3	
VITAFOL NANO	T3	
VITAFOL ULTRA	T3	
VITAFOL-OB	T1	
VITAFOL-OB+DHA	T3	
VITAFOL-ONE	T3	
VITAMEDMD ONE RX	T3	
VITAMEDMD REDICHEW RX ( <i>prenatal no.42/folic acid</i> )	T3	
VITAPEARL	T3	
VITATRUE	T3	

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## List of Prescription Medications

### PRE-NATAL VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>PRENATAL VITAMINS WITH LOW OR NO IRON</b>		
CITRANATAL B-CALM	T3	
DUET DHA 400	T3	
PRENATE DHA	T3	
PRENATE ELITE	T3	
PRENATE MINI	T3	
PRENATE PIXIE	T3	
PRENATE STAR	T3	
R-NATAL OB	T1	
VITAFOL GUMMIES	T3	

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>o</sup>

<b>ALPHA-2 RECEPTOR ANTAGONIST ANTI-DEPRESSANTS</b>		
<i>mirtazapine</i>	T1	HD
<i>mirtazapine</i> (Remeron)	T1	HD
<b>ANTI-ANXIETY - BENZODIAZEPINES</b>		
<i>alprazolam</i>	T1	
<i>alprazolam</i> (Xanax Xr)	T1	
<i>alprazolam</i> (Xanax)	T1	
<i>chlordiazepoxide hcl</i>	T1	
<i>clorazepate dipotassium</i>	T1	
<i>diazepam 10 mg tablet</i> (Valium)	T1	
<i>diazepam 2 mg tablet</i> (Valium)	T1	
<i>diazepam 25 mg/5 ml oral conc</i>	T1	
<i>diazepam 5 mg tablet</i> (Valium)	T1	
<i>diazepam 5 mg/5 ml oral cup</i>	T1	
<i>lorazepam</i>	T1	
<i>diazepam 5 mg/5 ml solution</i>	T1	
<i>diazepam 5 mg/ml oral conc</i>	T1	
<i>lorazepam</i>	T1	
<i>lorazepam</i> (Ativan)	T1	
<i>oxazepam</i>	T1	
<b>ANTI-ANXIETY DRUGS</b>		
<i>buspirone hcl</i>	T1	HD
<i>meprobamate</i>	T1	

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIDEPRESSANT - POSTPARTUM DEPRESSION (PPD)</b>		
ZURZUVAE 20 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 25 MG CAPSULE	T3	PA QL(28 CAPS/270 DAYS) SP HD
ZURZUVAE 30 MG CAPSULE	T3	PA QL(14 CAPS/270 DAYS) SP HD
<b>BIPOLAR DISORDER DRUGS</b>		
EQUETRO	T3	HD
<i>lithium carbonate</i>	T1	HD
<i>lithium carbonate</i> (Lithobid)	T1	HD
<i>lithium citrate</i>	T1	HD
<b>MAOIS -NON-SELECTIVE, IRREVERSIBLE ANTI-DEPRESSANTS</b>		
MARPLAN	T3	QL(12 TABS/DAY)
<i>phenelzine sulfate</i> (Nardil)	T1	
<i>tranylcypromine sulfate</i> (Parnate)	T1	
<b>MONOAMINE OXIDASE (MAO) INHIBITOR ANTI-DEPRESSANTS</b>		
EMSAM 12 MG/24 HOURS PATCH	T3	QL(1 PATCH/DAY)
EMSAM 6 MG/24 HOURS PATCH	T3	QL(2 PATCHES/DAY)
EMSAM 9 MG/24 HOURS PATCH	T3	QL(1 PATCH/DAY)
<b>NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIs)</b>		
<i>bupropion hcl 100 mg tablet</i>	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl 75 mg tablet</i>	T1	QL(6 TABS/DAY) HD
<i>bupropion hcl sr 100 mg tablet</i> (Wellbutrin Sr)	T1	QL(4 TABS/DAY) HD
<i>bupropion hcl sr 150 mg tablet</i> (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl sr 200 mg tablet</i> (Wellbutrin Sr)	T1	QL(2 TABS/DAY) HD
<i>bupropion hcl xl 150 mg tablet</i> (Wellbutrin XL)	T1	QL(3 TABS/DAY) HD
<i>bupropion hcl xl 300 mg tablet</i> (Wellbutrin XL)	T1	QL(1 TAB/DAY) HD
<b>SELECTIVE SEROTONIN 5-HT<sub>2A</sub> INVERSE AGONISTS (SSiAs)</b>		
NUPLAZID	T3	PA SP HD
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs)</b>		
<i>citalopram hbr 10 mg tablet</i> (Celexa)	T1	QL(6 TABS/DAY) HD
<i>citalopram hbr 10 mg/5 ml soln</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 20 mg tablet</i> (Celexa)	T1	QL(3 TABS/DAY) HD
<i>citalopram hbr 20 mg/10 ml cup</i>	T1	QL(30 MLS/DAY) HD
<i>citalopram hbr 40 mg tablet</i> (Celexa)	T1	QL(1 TAB/DAY) HD

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)</b>		
<i>escitalopram 10 mg tablet (Lexapro)</i>	T1	QL(2 TABS/DAY) HD
<i>escitalopram 10 mg/10 ml cup</i>	T1	QL(20 MLS/DAY) HD
<i>escitalopram 20 mg tablet (Lexapro)</i>	T1	QL(1 TAB/DAY) HD
<i>escitalopram 5 mg tablet (Lexapro)</i>	T1	QL(4 TABS/DAY) HD
<i>escitalopram oxalate 5 mg/5 ml</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml soln cup</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine 20 mg/5 ml solution</i>	T1	QL(20 MLS/DAY) HD
<i>fluoxetine hcl</i>	T1	QL(4 CAPS/28 DAYS) HD
<i>fluoxetine hcl 10 mg capsule (Prozac)</i>	T1	QL(8 CAPS/DAY) HD
<i>fluoxetine hcl 10 mg tablet</i>	T1	HD
<i>fluoxetine hcl 20 mg capsule (Prozac)</i>	T1	QL(4 CAPS/DAY) HD
<i>fluoxetine hcl 20 mg tablet</i>	T1	HD
<i>fluoxetine hcl 40 mg capsule (Prozac)</i>	T1	QL(2 CAPS/DAY) HD
<i>fluoxetine hcl 60 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>fluvoxamine er 100 mg capsule</i>	T1	QL(3 CAPS/DAY) HD
<i>fluvoxamine er 150 mg capsule</i>	T1	QL(2 CAPS/DAY) HD
<i>fluvoxamine maleate 100 mg tab</i>	T1	QL(3 TABS/DAY) HD
<i>fluvoxamine maleate 25 mg tab</i>	T1	QL(12 TABS/DAY) HD
<i>fluvoxamine maleate 50 mg tab</i>	T1	QL(6 TABS/DAY) HD
<i>paroxetine cr 12.5 mg tablet (Paxil Cr)</i>	T1	QL(1 TAB/DAY) HD
<i>paroxetine cr 25 mg tablet (Paxil Cr)</i>	T1	QL(3 TABS/DAY) HD
<i>paroxetine cr 37.5 mg tablet (Paxil Cr)</i>	T1	QL(2 TABS/DAY) HD
<i>paroxetine er 12.5 mg tablet (Paxil Cr)</i>	T1	QL(1 TAB/DAY) HD
<i>paroxetine er 25 mg tablet (Paxil Cr)</i>	T1	QL(3 TABS/DAY) HD
<i>paroxetine er 37.5 mg tablet (Paxil Cr)</i>	T1	QL(2 TABS/DAY) HD
<i>paroxetine hcl 10 mg tablet (Paxil)</i>	T1	QL(6 TABS/DAY) HD
<i>paroxetine hcl 10 mg/5 ml susp</i>	T1	QL(30 MLS/DAY) HD
<i>paroxetine hcl 20 mg tablet (Paxil)</i>	T1	QL(3 TABS/DAY) HD
<i>paroxetine hcl 30 mg tablet (Paxil)</i>	T1	QL(2 TABS/DAY) HD
<i>paroxetine hcl 40 mg tablet (Paxil)</i>	T1	QL(1 TAB/DAY) HD
<i>sertraline 150 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>sertraline 20 mg/ml oral conc (Zoloft)</i>	T1	QL(10 MLS/DAY) HD
<i>sertraline 200 mg capsule</i>	T1	QL(1 CAP/DAY) HD
<i>sertraline hcl 100 mg tablet (Zoloft)</i>	T1	QL(2 TABS/DAY) HD

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HD – May require home delivery pharmacy

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIs) (cont.)</b>		
<i>sertraline hcl 25 mg tablet</i> (Zoloft)	T1	QL(8 TABS/DAY) HD
<i>sertraline hcl 50 mg tablet</i> (Zoloft)	T1	QL(4 TABS/DAY) HD
<b>SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIs)</b>		
<i>nefazodone hcl</i>	T1	HD
<i>trazodone hcl</i>	T1	HD
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIs)</b>		
<i>desvenlafaxine succnt er 100mg</i> (Pristiq)	T1	QL(4 TABS/DAY) HD
<i>desvenlafaxine succnt er 25 mg</i> (Pristiq)	T1	QL(16 TABS/DAY) HD
<i>desvenlafaxine succnt er 50 mg</i> (Pristiq)	T1	QL(1 TAB/DAY) HD
<i>duloxetine hcl dr 20 mg cap</i> (Cymbalta)	T1	QL(6 CAPS/DAY) HD
<i>duloxetine hcl dr 30 mg cap</i> (Cymbalta)	T1	QL(4 CAPS/DAY) HD
<i>duloxetine hcl dr 40 mg cap</i>	T1	QL(3 CAPS/DAY) HD
<i>duloxetine hcl dr 60 mg cap</i> (Cymbalta)	T1	QL(2 CAPS/DAY) HD
<i>venlafaxine hcl 100 mg tablet</i>	T1	QL(3 TABS/DAY) HD
<i>venlafaxine hcl 25 mg tablet</i>	T1	QL(15 TABS/DAY) HD
<i>venlafaxine hcl 37.5 mg tablet</i>	T1	QL(10 TABS/DAY) HD
<i>venlafaxine hcl 50 mg tablet</i>	T1	QL(7 TABS/DAY) HD
<i>venlafaxine hcl 75 mg tablet</i>	T1	QL(5 TABS/DAY) HD
<i>venlafaxine hcl er 150 mg cap</i> (Effexor Xr)	T1	QL(2 CAPS/DAY) HD
<i>venlafaxine hcl er 150 mg tab</i>	T1	QL(2 TABS/DAY) HD
<i>venlafaxine hcl er 225 mg tab</i>	T1	QL(1 TAB/DAY) HD
<i>venlafaxine hcl er 37.5 mg cap</i> (Effexor Xr)	T1	QL(8 CAPS/DAY) HD
<i>venlafaxine hcl er 37.5 mg tab</i>	T1	QL(8 TABS/DAY) HD
<i>venlafaxine hcl er 75 mg cap</i> (Effexor Xr)	T1	QL(4 CAPS/DAY) HD
<i>venlafaxine hcl er 75 mg tab</i>	T1	QL(4 TABS/DAY) HD
<b>SSRI AND 5HT1A PARTIAL AGONIST ANTI-DEPRESSANTS</b>		
<i>vilazodone hcl 10 mg tablet</i> (Viibryd)	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 20 mg tablet</i> (Viibryd)	T1	QL(1 TAB/DAY) HD
<i>vilazodone hcl 40 mg tablet</i> (Viibryd)	T1	HD
<b>SSRI, SEROTONIN RECEPTOR MODULATOR ANTI-DEPRESSANTS</b>		
TRINTELLIX 10 MG TABLET	T2	QL(1 TAB/DAY)
TRINTELLIX 20 MG TABLET	T2	
TRINTELLIX 5 MG TABLET	T2	QL(1 TAB/DAY)

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Anxiety/Depression/Bipolar Disorder)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TRICYCLIC ANTI-DEPRESSANT-BENZODIAZEPINE COMBINATNS</b>		
<i>amitriptyline/chlordiazepoxide</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANT-PHENOTHIAZINE COMBINATNS</b>		
<i>perphenazine/amitriptyline hcl</i>	T1	HD
<b>TRICYCLIC ANTI-DEPRESSANTS, REL.NON-SEL.REUPT-INHIB</b>		
<i>amitriptyline hcl</i>	T1	HD
<i>amoxapine</i>	T1	HD
<i>clomipramine hcl (Anafranil)</i>	T1	HD
<i>desipramine hcl</i>	T1	HD
<i>doxepin 10 mg capsule</i>	T1	HD
<i>doxepin 10 mg/ml oral conc</i>	T1	HD
<i>doxepin 100 mg capsule</i>	T1	HD
<i>doxepin 150 mg capsule</i>	T1	HD
<i>doxepin 25 mg capsule</i>	T1	HD
<i>doxepin 50 mg capsule</i>	T1	HD
<i>doxepin 75 mg capsule</i>	T1	HD
<i>imipramine hcl</i>	T1	HD
<i>imipramine pamoate</i>	T1	HD
<i>nortriptyline hcl</i>	T1	HD
<i>nortriptyline hcl (Pamelor)</i>	T1	HD
<i>protriptyline hcl</i>	T1	HD
<i>trimipramine maleate</i>	T1	HD
<b>PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>10</sup></b>		
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE</b>		
<i>lisdexamfetamine 10 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 10 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 20 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 20 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 30 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 30 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 40 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 40 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 50 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 50 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

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# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ADRENERGICS, AROMATIC, NON-CATECHOLAMINE (cont.)</b>		
<i>lisdexamfetamine 60 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<i>lisdexamfetamine 60 mg tb chew (Vyvanse)</i>	T1	PA QL(1 TAB/DAY)
<i>lisdexamfetamine 70 mg capsule (Vyvanse)</i>	T1	PA QL(1 CAP/DAY)
<b>TX FOR ADHD - SELECTIVE ALPHA-2 RECEPTOR AGONIST</b>		
<i>clonidine hcl er 0.1 mg tablet (Kapvay)</i>	T1	
<i>guanfacine hcl (Intuniv)</i>	T1	HD
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY</b>		
DAYTRANA ( <i>methylphenidate</i> )	T3	PA QL(1 PATCH/DAY)
<i>dexmethylphenidate hcl (Focalin Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>dexmethylphenidate hcl (Focalin)</i>	T1	PA
FOCALIN ( <i>dexmethylphenidate hcl</i> )	T3	PA ST
METHYLIN ( <i>methylphenidate hcl</i> )	T3	PA
<i>methylphenidate (Daytrana)</i>	T1	PA QL(1 PATCH/DAY)
<i>methylphenidate er 10 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 10 mg tab</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 15 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 18 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 18 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 20 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 20 mg tab</i>	T1	PA QL(3 TABS/DAY)
<i>methylphenidate er 27 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 27 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 30 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 36 mg tab (Concerta)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 36 mg tab (Relexxii)</i>	T1	PA QL(2 TABS/DAY)
<i>methylphenidate er 40 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 50 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 54 mg tab (Concerta)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 54 mg tab (Relexxii)</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er 60 mg cap (Aptensio Xr)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er 72 mg tab</i>	T1	PA QL(1 TAB/DAY)
<i>methylphenidate er(la) 10mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 20mg cp (Ritalin La)</i>	T1	PA QL(1 CAP/DAY)

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## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Attention Deficit Hyperactivity Disorder)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TX FOR ATTENTION DEFICIT-HYPERACT (ADHD)/NARCOLEPSY (cont.)</b>		
<i>methylphenidate er(la) 30mg cp</i> (Ritalin La)	T1	PA QL(2 CAPS/DAY)
<i>methylphenidate er(la) 40mg cp</i> (Ritalin La)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate er(la) 60mg cp</i>	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl</i>	T1	PA
<i>methylphenidate hcl</i> (Metadate Cd)	T1	PA QL(1 CAP/DAY)
<i>methylphenidate hcl</i> (Methylin)	T1	PA
<i>methylphenidate hcl</i> (Ritalin)	T1	PA
QUILLIVANT XR	T3	PA QL(12 MLS/DAY)
RITALIN ( <i>methylphenidate hcl</i> )	T3	PA ST
<b>TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE</b>		
<i>atomoxetine hcl 10 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 100 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 18 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 25 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 40 mg capsule</i> (Strattera)	T1	QL(1 CAP/DAY) HD
<i>atomoxetine hcl 60 mg capsule</i> (Strattera)	T1	HD
<i>atomoxetine hcl 80 mg capsule</i> (Strattera)	T1	HD
<b>PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>10</sup></b>		
<b>ANTI-PSYCH, DOPAMINE ANTAG., DIPHENYLBUTYLPIPERIDINES</b>		
<i>pimozide</i>	T1	
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGNST</b>		
<i>asenapine maleate</i> (Saphris)	T1	
CAPLYTA	T3	ST QL(1 CAP/DAY)
<i>clozapine</i>	T1	
<i>clozapine</i> (Clozaril)	T1	
<i>lurasidone hcl 120 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 20 mg tablet</i> (Latuda)	T1	
<i>lurasidone hcl 40 mg tablet</i> (Latuda)	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 60 mg tablet</i> (Latuda)	T1	QL(1 TAB/DAY)
<i>lurasidone hcl 80 mg tablet</i> (Latuda)	T1	
<i>olanzapine</i>	T1	
<i>olanzapine</i> (Zyprexa Zydis)	T1	
<i>olanzapine</i> (Zyprexa)	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-PSYCHOTIC, ATYPICAL, DOPAMINE, SEROTONIN ANTAGONIST (cont.)</b>		
<i>paliperidone er 1.5 mg tablet</i>	T1	
<i>paliperidone er 3 mg tablet</i> (Invega)	T1	QL(1 TAB/DAY)
<i>paliperidone er 6 mg tablet</i> (Invega)	T1	
<i>paliperidone er 9 mg tablet</i> (Invega)	T1	
<i>quetiapine fumarate</i> (Seroquel Xr)	T1	
<i>quetiapine fumarate 100 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 200 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 25 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 300 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 400 mg tab</i> (Seroquel)	T1	
<i>quetiapine fumarate 50 mg tab</i> (Seroquel)	T1	
<i>risperidone</i>	T1	
<i>risperidone</i> (Risperdal)	T1	
SAPHRIS ( <i>asenapine maleate</i> )	T3	ST
SECUADO	T3	ST
SEROQUEL ( <i>quetiapine fumarate</i> )	T3	ST
SEROQUEL XR ( <i>quetiapine fumarate</i> )	T3	ST
<i>ziprasidone hcl</i> (Geodon)	T1	
<b>ANTI-PSYCHOTIC-ATYPICAL, D3/D2 PARTIAL AG-5HT MIXED</b>		
VRAYLAR 1.5 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 3 MG CAPSULE	T3	ST QL(1 CAP/DAY)
VRAYLAR 4.5 MG CAPSULE	T3	ST
VRAYLAR 6 MG CAPSULE	T3	ST
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED</b>		
<i>aripiprazole</i>	T1	
<i>aripiprazole 1 mg/ml solution</i>	T1	
<i>aripiprazole 10 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 15 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 2 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 20 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 30 mg tablet</i> (Abilify)	T1	
<i>aripiprazole 5 mg tablet</i> (Abilify)	T1	QL(1 TAB/DAY)
REXULTI 0.25 MG TABLET	T2	ST QL(1 TAB/DAY)

T1 – Typically Generics

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T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### PSYCHOTHERAPEUTIC DRUGS (Schizophrenia/Anti-Psychotics)<sup>10</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED (cont.)</b>		
REXULTI 0.5 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 1 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 2 MG TABLET	T2	ST QL(1 TAB/DAY)
REXULTI 3 MG TABLET	T2	ST
REXULTI 4 MG TABLET	T2	ST
<b>ANTI-PSYCHOTICS, DOPAMINE AND SEROTONIN ANTAGONISTS</b>		
<i>loxapine succinate</i>	T1	
<b>ANTIPSYCHOTICS, DOPAMINE ANTAGONISTS, THIOXANTHENES</b>		
<i>thiothixene</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONISTS, BUTYROPHENONES</b>		
<i>haloperidol</i>	T1	
<i>haloperidol lactate</i>	T1	
<b>ANTI-PSYCHOTICS, DOPAMINE ANTAGONST, DIHYDROINDOLONES</b>		
<i>molindone hcl</i>	T1	
<b>ANTI-PSYCHOTICS, PHENOTHIAZINES</b>		
<i>chlorpromazine hcl</i>	T1	
<i>fluphenazine hcl</i>	T1	
<i>perphenazine</i>	T1	
<i>thioridazine hcl</i>	T1	
<i>trifluoperazine hcl</i>	T1	
<b>SSRI-ANTI-PSYCH, ATYPICAL, DOPAMINE, SEROTONIN ANTAG</b>		
<i>olanzapine/fluoxetine hcl</i>	T1	
<b>NEUROACTIVE STEROID GABA-A RECEPTOR MODULATOR</b>		
ZTALMY	T3	PA QL(36 MLS/DAY) SP
<b>PSYCHOTHERAPEUTIC DRUGS (Sleep Disorders/Sedatives)</b>		
<b>NARCOLEPSY AND SLEEP DISORDER THERAPY AGENTS</b>		
<i>armodafinil</i> (Nuvigil)	T1	PA
<i>modafinil</i> (Provigil)	T1	PA
SUNOSI	T2	PA QL(1 TAB/DAY)
<b>SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives)</b>		
<b>ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT</b>		
LUMRYZ	T3	PA QL(1 PACK/DAY) SP HD
LUMRYZ STARTER PACK	T3	PA QL SP HD

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### SEDATIVE/HYPNOTICS (Sleep Disorders/Sedatives) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTI-NARCOLEPSY, ANTI-CATAPLEXY, SEDATIVE-TYPE AGENT (cont.)</b>		
SODIUM OXYBATE 0.5 G/ML SOLN	T3	PA QL(18 MLS/DAY) SP HD
XYWAV	T3	PA QL(18 MLS/DAY) SP HD
<b>BARBITURATES</b>		
<i>phenobarbital</i>	T1	
<b>HYPNOTICS, MELATONIN MT1/MT2 RECEPTOR AGONISTS</b>		
HETLIOZ LQ	T3	PA SP HD
<i>ramelteon</i> (Rozerem)	T1	QL(1 TAB/DAY)
<i>tasimelteon</i> (Hetlioz)	T1	PA SP
<b>SEDATIVE-HYPNOTICS - BENZODIAZEPINES</b>		
DORAL	T3	
<i>estazolam</i>	T1	
<i>flurazepam hcl</i>	T1	
HALCION ( <i>triazolam</i> )	T3	
<i>midazolam hcl</i>	T1	
QUAZEPAM	T1	
<i>temazepam</i> (Restoril)	T1	
<i>triazolam</i>	T1	
<i>triazolam</i> (Halcion)	T1	
<b>SEDATIVE-HYPNOTICS, NON-BARBITURATE</b>		
DAYVIGO	T2	ST QL(1 TAB/DAY)
<i>doxepin hcl 3 mg tablet</i> (Silenor)	T1	QL(1 TAB/DAY)
<i>doxepin hcl 6 mg tablet</i> (Silenor)	T1	
<i>eszopiclone</i> (Lunesta)	T1	
<i>zaleplon</i>	T1	
<i>zolpidem tart 1.75 mg tab sl</i>	T1	
<i>zolpidem tart 3.5 mg tablet sl</i>	T1	
<i>zolpidem tart er 12.5 mg tab</i>	T1	
<i>zolpidem tart er 6.25 mg tab</i>	T1	QL(1 TAB/DAY)
<i>zolpidem tartrate 10 mg tablet</i> (Ambien)	T1	
<i>zolpidem tartrate 5 mg tablet</i> (Ambien)	T1	

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## List of Prescription Medications

SKIN PREPS (Miscellaneous)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTISEPTICS,GENERAL</b>		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
<b>IRRIGANTS</b>		
<i>acetic acid</i>	T1	
<i>neomycin sulf/polymyxin b sulf</i>	T1	
PHYSIOLYTE ( <i>physiological irrig soln no.1</i> )	T3	
PHYSIOSOL ( <i>physiological irrig soln no.1</i> )	T3	
<i>ringer's solution</i>	T1	
<i>ringer's solution, lactated</i>	T1	
<i>sod,pot chlor/mag/sod,pot phos</i>	T3	
<i>sodium chloride 0.9% irrig</i>	T1	
SODIUM CHLORIDE 0.9% IRRIG.	T3	
<i>sodium chloride 0.9% prcss sol</i>	T1	
<i>sodium chloride irrig solution</i>	T1	

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T3 – Typically Non-Preferred Brands

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## List of Prescription Medications

SKIN PREPS (Miscellaneous) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>IRRIGANTS (cont.)</b>		
SORBITOL	T1	
SORBITOL-MANNITOL	T1	
water for irrigation, sterile	T1	
<b>OXIDIZING AGENTS</b>		
hydrogen peroxide	T1	
<b>SKIN PREPS (Pain Relief And Inflammatory Disease)</b>		
<b>ANTI-PSORIATIC AGENTS, SYSTEMIC</b>		
acitretin	T1	
BIMZELX	T3	PA QL(2 MLS/28 DAYS) SP HD
BIMZELX AUTOINJECTOR	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX (2 SYRINGES)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX 150 MG/ML SYRINGE	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX 75 MG/0.5 ML SYRINGE	T3	PA QL(0.5 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY (2 PENS)	T3	PA QL(2 MLS/28 DAYS) SP HD
COSENTYX SENSOREADY PEN	T3	PA QL(1 ML/28 DAYS) SP HD
COSENTYX UNOREADY PEN	T3	PA QL(2 MLS/28 DAYS) SP HD
ILUMYA	T3	PA QL(1 UNIT/84 DAYS) SP HD
methoxsalen	T1	
SILIQ	T3	PA QL(3 MLS/28 DAYS) SP HD
SKYRIZI	T2	PA QL(150 MG/84 DAYS) SP HD
SKYRIZI PEN	T2	PA QL(150 MG/84 DAYS) SP HD
SOTYKTU	T2	PA QL(1 TAB/DAY) SP HD
SPEVIGO	T3	PA QL(2 MLS/28 DAYS) SP HD
TALTZ AUTOINJECTOR	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (2 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ AUTOINJECTOR (3 PACK)	T2	PA QL(1 AUTO-INJECTOR/28 DAYS) SP HD
TALTZ SYRINGE	T2	PA QL(1 SYRINGE/28 DAYS) SP HD
<b>TOPICAL ANTI-INFLAMMATORY, NSAIDS</b>		
diclofenac sodium 1% gel	T1	QL(1000 GMS/30 DAYS) HD
<b>SKIN PREPS (Skin Conditions)</b>		
<b>ACNE AGENTS, SYSTEMIC</b>		
ABSORICA (isotretinoin)	T3	
isotretinoin (Absorica)	T1	

T1 – Typically Generics

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T2 – Typically Preferred Brands

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

## SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ACNE AGENTS, TOPICAL</b>		
ACZONE 7.5% GEL PUMP ( <i>dapsone</i> )	T3	
<i>adapalene/benzoyl peroxide</i>	T1	
<i>adapalene/benzoyl peroxide</i> (Epiduo Forte)	T1	
<i>clindamycin phos/benzoyl perox</i>	T1	
<i>clindamycin phos/benzoyl perox</i> (Acanya)	T1	
<i>clindamycin/tretinoin</i> (Veltin)	T1	
<i>clindamycin/tretinoin</i> (Ziana)	T1	
<i>clindamycin-benzoyl perox 1-5%</i>	T1	
<i>clindamycin-bnz perox 1-5% pmp</i>	T1	
<i>dapsone 5% gel</i> (Aczone)	T1	
<i>dapsone 7.5% gel pump</i> (Aczone)	T1	
KLARON ( <i>sulfacetamide sodium</i> )	T3	
<i>neuac gel</i>	T1	
ONEXTON ( <i>clindamycin phos/benzoyl perox</i> )	T3	
<i>sulfacetamide sodium</i> (Klaron)	T1	
TWYNEO	T3	
<b>ANTI-PERSPIRANTS</b>		
DRYSOL	T3	
<b>ANTI-PSORIATICS AGENTS</b>		
<i>anthralin</i>	T1	
<i>calcipotriene 0.005% cream</i>	T1	
CALCIPOTRIENE 0.005% FOAM	T3	
<i>calcipotriene 0.005% ointment</i>	T1	
<i>calcipotriene 0.005% solution</i>	T1	
<i>calcitriol 3 mcg/g ointment</i> (Vectical)	T1	QL(800 GMS/30 DAYS)
<i>tazarotene 0.05% cream</i> (Tazorac)	T1	
<i>tazarotene 0.05% gel</i> (Tazorac)	T1	
<i>tazarotene 0.1% cream</i> (Tazorac)	T1	
<i>tazarotene 0.1% gel</i> (Tazorac)	T1	
TAZORAC ( <i>tazarotene</i> )	T3	
<b>ANTI-SEBORRHEIC AGENTS</b>		
OVACE PLUS	T3	
<i>selenium sulfide</i>	T1	
<i>sulfacetamide sodium</i>	T1	

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CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTISEPTICS, GENERAL</b>		
<i>alcohol antiseptic pads</i>	T1	
ALCOHOL PREP PADS	T1	
ALCOHOL SWAB	T1	
ALCOHOL SWABS	T1	
ALCOHOL WIPES	T1	
CARETOUCH ALCOHOL PREP PAD	T1	
CURITY ALCOHOL PREPS	T1	
DROPSAFE PREP PADS	T1	
EASY COMFORT ALCOHOL PAD	T1	
EASY TOUCH ALCOHOL PREP PADS	T1	
INCONTROL ALCOHOL PADS	T1	
PRO COMFORT ALCOHOL PADS	T1	
PURE COMFORT ALCOHOL PAD	T1	
SINGLE USE SWAB	T1	
SURE COMFORT ALCOHOL	T1	
SURE-PREP ALCOHOL PREP PADS	T1	
TRUE COMFORT ALCOHOL PADS	T1	
TRUE COMFORT PRO ALCOHOL PADS	T1	
ULTILET ALCOHOL SWAB	T1	
WEBCOL	T1	
<b>ANTISEPTICS, MISCELLANEOUS</b>		
GUAIACOL	T1	
<b>EMOLLIENTS</b>		
<i>ammonium lactate</i>	T1	
HPR PLUS-MB HYDROGEL	T1	
XCLAIR	T3	
<b>IMMUNOMODULATORS</b>		
<i>imiquimod 5% cream packet</i>	T1	
<b>IRRITANTS/COUNTER-IRRITANTS</b>		
<i>methyl salicylate</i>	T1	
<b>JANUS KINASE (JAK) INHIBITORS</b>		
CIBINQO	T2	PA QL(30 TABS/30 DAYS) SP

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## List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>KERATOLYTICS</b>		
<i>benzebro 6% foaming cloths</i>	T1	
BENZEPRO 7% CREAMY WASH (benzoyl peroxide microspheres)	T3	
<i>benzoyl peroxide</i>	T1	
<i>benzoyl peroxide (Pacnex)</i>	T1	
ENZOCLEAR	T3	
INOVA	T3	
PACNEX ( <i>benzoyl peroxide</i> )	T3	
<i>podofilox</i>	T1	
<i>podofilox (Condylox)</i>	T1	
PR BENZOYL PEROXIDE ( <i>benzoyl peroxide microspheres</i> )	T3	
<i>silver nitrate</i>	T1	
<b>PROTECTIVES</b>		
PHARMABASE BARRIER ( <i>zinc oxide</i> )	T3	
<i>zinc oxide</i>	T1	
ZINC OXIDE	T1	
<b>ROSACEA AGENTS, TOPICAL</b>		
<i>azelaic acid (Finacea)</i>	T1	
<i>ivermectin 1% cream (Soolantra)</i>	T1	
<i>metronidazole</i>	T1	
<i>metronidazole (Metrocream)</i>	T1	
<i>metronidazole 0.75% cream (Metrocream)</i>	T1	
<i>metronidazole 0.75% lotion</i>	T1	
<i>metronidazole top 1% gel pump</i>	T1	
<i>metronidazole topical 0.75% gel</i>	T1	
<i>metronidazole topical 1% gel (Metrogel)</i>	T1	
SOOLANTRA ( <i>ivermectin</i> )	T3	
<b>TISSUE/WOUND ADHESIVES</b>		
ARTISS	T3	
TISSEEL VHSD	T3	
<b>TOP. ANTI-INFLAM., PHOSPHODIESTERASE-4 (PDE4) INHIB</b>		
EUCRISA	T2	ST
ZORYVE 0.15% CREAM	T2	ST QL(60 GMS/30 DAYS)

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# List of Prescription Medications

## SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL AGENTS, MISCELLANEOUS</b>		
MEDIHONEY	T3	
<i>trichloroacetic acid</i>	T3	
TRICHLOROACETIC ACID	T3	
TRICHLOROACETIC ACID ( <i>trichloroacetic acid</i> )	T3	
<b>TOPICAL ANTIBIOTIC PLEUROMUTILIN DERIVATIVES</b>		
ALTABAX	T3	
<b>TOPICAL ANTICHOLINERGIC HYPERHIDROSIS TX AGENTS</b>		
QBREXZA	T3	PA
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL</b>		
ALA-SCALP ( <i>hydrocortisone</i> )	T3	ST
<i>alclometasone dipropionate</i>	T1	
<i>amcinonide 0.1% cream</i>	T1	
AQUA GLYCOLIC HC	T3	
<i>betamethasone dipropionate</i>	T1	
<i>betamethasone valerate</i>	T1	
<i>betamethasone/propylene glyc</i>	T1	
<i>betamethasone/propylene glyc (Diprolene)</i>	T1	
BRYHALI	T3	ST
CAPEX SHAMPOO	T3	ST
<i>clobetasol 0.05% cream</i>	T1	
<i>clobetasol 0.05% gel</i>	T1	
<i>clobetasol 0.05% ointment (Temovate)</i>	T1	
<i>clobetasol 0.05% shampoo (Clobex)</i>	T1	
<i>clobetasol 0.05% solution</i>	T1	
<i>clobetasol 0.05% topical lotn</i>	T1	
<i>clobetasol prop 0.05% foam (Olux)</i>	T1	
<i>clobetasol prop 0.05% spray (Clobex)</i>	T1	
<i>clobetasol propionate/emoll</i>	T1	
<i>clocortolone pivalate (Cloderm)</i>	T1	
CLODAN 0.05% KIT	T3	ST
<i>clodan 0.05% shampoo (Clobex)</i>	T1	
CLODERM	T3	ST
CLODERM ( <i>clocortolone pivalate</i> )	T3	ST

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## List of Prescription Medications

### SKIN PREPS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
DERMA-SMOOTHIE-FS ( <i>fluocinolone acetonide</i> )	T3	ST
DERMA-SMOOTHIE-FS ( <i>fluocinolone/shower cap</i> )	T3	ST
<i>desonide</i>	T1	
<i>desonide</i> (Tridesilon)	T1	
<i>desoximetasone</i> (Topicort)	T1	
DIPROLENE ( <i>betamethasone/propylene glyc</i> )	T3	ST
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-Smoothie-Fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-Smoothie-Fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide</i> (Vanos)	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluocinolone acetonide</i>	T1	
<i>fluocinolone acetonide</i> (Derma-Smoothie-Fs)	T1	
<i>fluocinolone acetonide</i> (Synalar)	T1	
<i>fluocinolone/shower cap</i> (Derma-Smoothie-Fs)	T1	
<i>fluocinonide</i>	T1	
<i>fluocinonide</i> (Vanos)	T1	
<i>fluocinonide/emollient base</i>	T1	
<i>fluticasone prop 0.005% oint</i>	T1	
<i>fluticasone prop 0.05% cream</i>	T1	
<i>fluticasone prop 0.05% lotion</i>	T1	
<i>fluticasone propionate</i>	T1	
<i>halcinonide 0.1% solution</i>	T1	
<i>halobetasol propionate</i>	T1	
<i>hydrocortisone</i>	T1	
<i>hydrocortisone</i> (Ala-Scalp)	T1	
<i>hydrocortisone</i> (Anusol-Hc)	T1	
<i>hydrocortisone acetate</i>	T1	
<i>hydrocortisone butyr 0.1% cream</i>	T1	
<i>hydrocortisone butyr 0.1% oint</i>	T1	

T1 – Typically Generics

PA – Prior Authorization

AGE – Age Requirement

PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

# List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL ANTI-INFLAMMATORY STEROIDAL (cont.)</b>		
<i>hydrocortisone butyr 0.1% soln</i>	T1	
<i>hydrocortisone valerate</i>	T1	
<i>mometasone furoate 0.1% cream</i>	T1	
<i>mometasone furoate 0.1% oint</i>	T1	
<i>mometasone furoate 0.1% soln</i>	T1	
NUCORT	T3	ST
<i>prednicarbate</i>	T1	
SCALACORT DK	T3	ST
SYNALAR	T3	ST
SYNALAR ( <i>fluocinolone acetonide</i> )	T3	ST
SYNALARTS	T3	ST
TEMOVATE ( <i>clobetasol propionate</i> )	T3	ST
TEXACORT	T3	ST
TOPICORT ( <i>desoximetasone</i> )	T3	ST
<i>triamcinolone 0.025% cream</i>	T1	
<i>triamcinolone 0.025% lotion</i>	T1	
<i>triamcinolone 0.025% oint</i>	T1	
<i>triamcinolone 0.1% cream</i>	T1	
<i>triamcinolone 0.1% lotion</i>	T1	
<i>triamcinolone 0.1% ointment</i>	T1	
<i>triamcinolone 0.5% cream</i>	T1	
<i>triamcinolone 0.5% ointment</i>	T1	
<i>triamcinolone acetonide</i>	T1	
<b>TOPICAL ANTI-INFLAMMATORY STEROID-LOCAL ANESTHETIC</b>		
EPIFOAM	T2	
<i>hydrocortisone/pramoxine</i>	T1	
<i>lidocaine/hydrocortisone ac</i>	T1	
PRAMOSONE	T3	
<b>TOPICAL JANUS KINASE (JAK) INHIBITORS</b>		
OPZELURA	T3	
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS</b>		
<i>iodine/potassium iodide</i>	T1	
<i>iodine/sodium iodide</i>	T1	

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# List of Prescription Medications

SKIN PREPS (Skin Conditions) (cont.)		
Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>TOPICAL PREPARATIONS, ANTIBACTERIALS (cont.)</b>		
IODOFLEX	T3	
IODOSORB	T3	
silver nitrate	T1	
<b>TOPICAL VIT D ANALOG/ANTI-INFLAMMATORY STEROID</b>		
calcipotriene/betamethasone (Taclonex)	T1	
<b>TOPICAL/MUCOUS MEMBR./SUBCUT. ENZYMES</b>		
SANTYL	T3	QL(60 GMS/30 DAYS)
<b>VITAMIN A DERIVATIVES</b>		
adapalene 0.1% cream (Differin)	T1	PA
ADAPALENE 0.1% LOTION	T1	PA
adapalene 0.1% solution	T1	PA
adapalene 0.3% gel	T1	PA
adapalene 0.3% gel pump (Differin)	T1	PA
RETIN-A MICRO PUMP 0.08% GEL (tretinoin microspheres)	T3	PA
tretinoin 0.01% gel (Retin-A)	T1	
tretinoin 0.025% cream (Retin-A)	T1	PA
tretinoin 0.025% gel (Retin-A)	T1	
tretinoin 0.05% cream (Retin-A)	T1	PA
tretinoin 0.05% gel (Atralin)	T1	PA
tretinoin 0.1% cream (Retin-A)	T1	PA
tretinoin microspheres (Retin-A Micro Pump)	T1	PA
tretinoin microspheres (Retin-A Micro)	T1	PA
<b>SMOKING DETERRENENTS (Smoking Cessation)<sup>9</sup></b>		
<b>SMOKING DETERRENT AGENTS (GANGLIONIC STIM, OTHERS)</b>		
NICOTROL	T3	PPACA
NICOTROL NS	T3	PPACA
<b>SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST</b>		
APO-VARENICLINE 0.5 MG TABLET	T3	
APO-VARENICLINE 1 MG TABLET	T3	
CHANTIX	T3	PA
varenicline 0.5 mg tablet	T1	PPACA
varenicline 1 mg cont month bx	T1	PPACA
varenicline 1 mg tablet	T1	PPACA
varenicline starting month box	T1	PPACA

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## List of Prescription Medications

### SMOKING DETERRENTS (Smoking Cessation)<sup>9</sup> (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST</b>		
<i>bupropion hcl sr 150 mg tablet</i>	T1	PPACA
<b>THYROID PREPS (Hormonal Agents)</b>		
<b>ANTI-THYROID PREPARATIONS</b>		
<i>methimazole</i>	T1	HD
<i>propylthiouracil</i>	T1	HD
<b>THYROID HORMONES</b>		
<i>adthyza 120 mg tablet</i>	T1	HD
<i>adthyza 15 mg tablet</i>	T1	HD
<i>adthyza 30 mg tablet</i>	T1	HD
<i>adthyza 60 mg tablet</i>	T1	HD
<i>adthyza 90 mg tablet</i>	T1	HD
CYTOMEL ( <i>liothyronine sodium</i> )	T3	HD
<i>levothyroxine 100 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 112 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 125 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 137 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 150 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 175 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 200 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 25 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 300 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 50 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 75 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine 88 mcg tablet (Synthroid)</i>	T1	HD
<i>levothyroxine sodium (Synthroid)</i>	T1	HD
<i>liothyronine sodium (Cytomel)</i>	T1	HD
<i>thyroid,pork</i>	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (AIDS/HIV)</b>		
<b>CYTOCHROME P450 INHIBITORS</b>		
TYBOST	T3	SP
<b>CYSTIC FIBROSIS - INHALED OSMOTIC AGENTS</b>		
BRONCHITOL	T3	PA SP HD

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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>CYSTIC FIBROSIS-CFTR POTENTIATOR-CORRECTOR COMBIN.</b>		
ALYFTREK 10-50-125 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
ALYFTREK 4-20-50 MG TABLET	T3	PA QL(3 TABS/DAY) SP HD
ORKAMBI 100 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 100-125 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 150-188 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
ORKAMBI 200 MG-125 MG TABLET	T3	PA QL(4 TABS/DAY) SP HD
ORKAMBI 75-94 MG GRANULE PKT	T3	PA QL(2 PACKS/DAY) SP HD
SYMDEKO	T3	PA QL(2 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/150 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 100-50-75 MG/75MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
TRIKAFTA 50-25-37.5 MG/75 MG	T3	PA QL(3 TABS/DAY) SP HD
TRIKAFTA 80-40-60MG/59.5MG PKT	T3	PA QL(2 UNITS/DAY) SP HD
<b>CYSTIC FIB-TRANSMEMB CONDUCT.REG.(CFTR) POTENTIATOR</b>		
KALYDECO 13.4 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 150 MG TABLET	T3	PA QL(2 TABS/DAY) SP HD
KALYDECO 25 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 5.8 MG GRANULES PKT	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 50 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
KALYDECO 75 MG GRANULES PACKET	T3	PA QL(2 PACKS/DAY) SP HD
<b>LUNG SURFACTANTS</b>		
CUROSURF	T3	
INFASURF	T3	
SURVANTA	T3	
<b>MUCOLYTICS</b>		
PULMOZYME	T3	PA SP HD
<b>PULMONARY FIBROSIS - SYSTEMIC ENZYME INHIBITORS</b>		
OFEV	T2	PA SP HD
<b>SYSTEMIC ENZYME INHIBITORS</b>		
JOENJA	T3	PA QL(2 TABS/DAY) SP
VIJOICE 125 MG TABLET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 250 MG DAILY DOSE PACK	T3	PA QL(2 TABS/DAY) SP
VIJOICE 50 MG GRANULE PACKET	T3	PA QL(1 TAB/DAY) SP
VIJOICE 50 MG TABLET	T3	PA QL(1 TAB/DAY) SP
ZOKINVY	T3	PA QL(4 CAPS/DAY) SP

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ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Asthma/COPD/Respiratory) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>THYMIC STROMAL LYMPHOPOIETIN (TSLP) INHIBITORS</b>		
TEZSPIRE 210 MG/1.91 ML PEN	T2	PA QL(1 PEN/28 DAYS) SP HD
TEZSPIRE 210 MG/1.91 ML SYRING	T2	PA SP HD

### UNCLASSIFIED DRUG PRODUCTS (Blood Modifiers/Bleeding Disorders)

<b>SPLEEN TYROSINE KINASE INHIBITORS</b>		
TAVALISSE	T2	PA SP

### UNCLASSIFIED DRUG PRODUCTS (Blood Pressure/Heart Medications)

<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
<i>icatibant acetate</i> (Firazyr)	T1	PA SP HD
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR	T3	PA SP HD
ORLADEYO	T3	PA QL(1 CAP/DAY) SP

### UNCLASSIFIED DRUG PRODUCTS (Cancer)

<b>CHEMOTHERAPY RESCUE/ANTIDOTE AGENTS</b>		
<i>leucovorin calcium</i>	T1	CSL
<i>mesna</i> (Mesnex)	T1	SP CSL
MESNEX ( <i>mesna</i> )	T3	SP CSL
VISTOGARD	T3	SP CSL

### UNCLASSIFIED DRUG PRODUCTS (Dental Products)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DENTAL AIDS AND PREPARATIONS</b>		
<i>chlorhexidine gluconate</i> (Peridex)	T1	
PERIDEX ( <i>chlorhexidine gluconate</i> )	T3	
<i>triamcinolone 0.1% paste</i>	T1	
<i>triamcinolone acetonide</i>	T1	
<b>PERIODONTAL COLLAGENASE INHIBITORS</b>		
<i>doxycycline hyclate 20 mg tab</i>	T1	

### UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction)

<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED)</b>		
<i>avanafil</i> (Stendra)	T1	QL(8 TABS/30 DAYS)
CAVERJECT	T3	PA QL(6 INJECTIONS/30 DAYS)
CIALIS 10 MG TABLET ( <i>tadalafil</i> )	T3	ST QL(8 TABS/30 DAYS)
CIALIS 20 MG TABLET ( <i>tadalafil</i> )	T3	ST QL(8 TABS/30 DAYS)

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T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Erectile Dysfunction) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>DRUGS TO TREAT ERECTILE DYSFUNCTION (ED) (cont.)</b>		
CIALIS 5 MG TABLET ( <i>tadalafil</i> )	T3	ST QL(1 TAB/DAY)
EDEX	T3	PA QL(6 INJECTIONS/30 DAYS)
IFE-BIMIX 30/1	T2	
MUSE	T3	PA QL(6 SUPPS/30 DAYS)
<i>sildenafil 100 mg tablet</i> (Viagra)	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 25 mg tablet</i> (Viagra)	T1	QL(8 TABS/30 DAYS) HD
<i>sildenafil 50 mg tablet</i> (Viagra)	T1	QL(8 TABS/30 DAYS) HD
STENDRA ( <i>avanafil</i> )	T3	ST QL(8 TABS/30 DAYS)
<i>tadalafil 10 mg tablet</i> (Cialis)	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 2.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>tadalafil 20 mg tablet</i> (Cialis)	T1	QL(8 TABS/30 DAYS) HD
<i>tadalafil 5 mg tablet</i> (Cialis)	T1	QL(1 TAB/DAY) HD
<i>ildenafil hcl</i>	T1	QL(8 TABS/30 DAYS)
VIAGRA ( <i>sildenafil citrate</i> )	T3	ST QL(8 TABS/30 DAYS)

### UNCLASSIFIED DRUG PRODUCTS (Eye Conditions)

#### NICOTINIC RECEPT.PARTIAL AGONIST, ALPHA4BETA2 SPEC

TYRVAYA	T2	QL(8.4 MLS/30 DAYS)
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### UNCLASSIFIED DRUG PRODUCTS (Gastrointestinal/Heartburn)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ORAL MUCOSITIS/STOMATITIS AGENTS</b>		
GELCLAIR	T3	
ORAMAGICRX	T3	
<b>PPAR AGONIST</b>		
IQIRVO	T2	PA SP HD
<b>SALIVA STIMULANT AGENTS</b>		
NUMOISYN	T3	
<b>THYROID HORMONE RECEPTOR (THR) AGONIST</b>		
REZDIFFRA	T3	PA QL(1 TAB/DAY) SP HD

### UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents)

#### GROWTH HORMONE RECEPTOR ANTAGONISTS

SOMAVERT	T2	PA SP HD
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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Hormonal Agents) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>HYPERPARATHYROID TX AGENTS - VITAMIN D ANALOG-TYPE</b>		
<i>doxercalciferol</i>	T1	
<i>paricalcitol</i>	T1	SP HD
<i>paricalcitol</i> (Zemplar)	T1	SP HD
RAYALDEE	T3	
ZEMPLAR ( <i>paricalcitol</i> )	T3	SP HD
<b>MENOPAUSAL SYMPT SUPP-SEL ESTROGEN RECEP MODULATOR</b>		
OSPHENA	T3	QL(30 TABS/30 DAYS) HD
<b>UNCLASSIFIED DRUG PRODUCTS (Miscellaneous)</b>		
<b>ABORTIFACIENT-PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX	T3	
<i>mifepristone 200 mg tablet</i>	T1	
<b>AGENTS TO TX PERIODIC PARALYSIS - CARBON ANHYD INH</b>		
<i>dichlorphenamide</i> (Keveyis)	T1	PA SP HD
<b>AMMONIA INHIBITORS</b>		
CARBAGLU ( <i>carglumic acid</i> )	T3	SP HD
<i>carglumic acid</i> (Carbaglu)	T1	SP HD
<b>ANTI-ALCOHOLIC PREPARATIONS</b>		
<i>acamprosate calcium</i>	T1	
<i>disulfiram</i>	T1	
<b>ANTI-FIBROTIC THERAPY - PYRIDONE ANALOGS</b>		
<i>pirfenidone 267 mg capsule</i>	T1	PA SP HD
<i>pirfenidone 267 mg capsule</i> (Esbriet)	T1	PA SP HD
<i>pirfenidone 801 mg capsule</i> (Esbriet)	T1	PA SP HD
<b>CALCIMIMETIC,PARATHYROID CALCIUM ENHANCER</b>		
<i>cinacalcet hcl</i> (Sensipar)	T1	SP
<b>CRYOPRESERVATIVE AGENTS</b>		
<i>dimethyl sulfoxide</i>	T1	
<b>GENERAL INHALATION AGENTS</b>		
HYPER-SAL	T3	
<i>nebusal 3% vial</i>	T1	
NEBUSAL 6% VIAL	T3	
<i>sodium chloride 0.9% inhal vl</i>	T1	
<i>sodium chloride 10% vial</i>	T1	

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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>GENERAL INHALATION AGENTS (cont.)</b>		
sodium chloride 3% vial	T1	
sodium chloride 7% vial	T1	
sodium chloride for inhalation	T1	
<b>GENETIC D/O TX - SMN PROTEIN DEFICIENCY TREATMENT</b>		
EVRYSDI	T3	PA SP HD
<b>GLUCOSYLCERAMIDE SYNTHASE (GCS) INHIBITOR</b>		
CERDELGA	T2	PA SP HD
miglustat (Zavesca)	T1	PA SP
miglustat (Zavesca)	T1	PA SP HD
OPFOLDA	T3	PA QL(8 CAPS/30 DAYS) SP HD
<b>HYDROXYPHENYL-PYRUVATE DIOXYGENASE(HPPD) INHIBITOR</b>		
nitisinone (Orfadin)	T1	PA SP HD
NITYR	T2	PA SP
ORFADIN	T3	PA SP
ORFADIN (nitisinone)	T3	PA SP
<b>HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) TX AGENTS</b>		
ADDYI	T3	PA QL(1 TAB/DAY)
VYLEESI	T3	PA QL(8 AUTO-INJS/30 DAYS) SP
<b>MENOPAUSAL SYMPTOMS SUPPRESSANT - SSRIs</b>		
paroxetine mesylate	T1	QL(1 CAP/DAY) HD
<b>METABOLIC DISEASE ENZYME REPLACE, HYPOPHOSPHATASIA</b>		
STRENSIQ	T2	PA SP
<b>METABOLIC DISEASE ENZYME REPLACEMENT, MOCD</b>		
NULIBRY	T3	PA SP
<b>METALLIC POISON, AGENTS TO TREAT</b>		
CHEMET	T3	
deferasirox (Exjade)	T1	SP HD
deferasirox (Jadenu Sprinkle)	T1	SP HD
deferasirox (Jadenu)	T1	SP HD
deferiprone (Ferriprox (3 Times A Day))	T1	PA SP HD
deferiprone (Ferriprox)	T1	PA SP
EXJADE (deferasirox)	T3	PA SP HD
FERRIPROX (2 TIMES A DAY)	T3	PA SP

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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METALLIC POISON, AGENTS TO TREAT (cont.)</b>		
FERRIPROX 100 MG/ML SOLUTION	T3	PA SP
GALZIN	T3	SP
RADIOGARDASE	T3	
<i>trientine hcl 250 mg capsule (Syprine)</i>	T1	PA SP HD
TRIENTINE HCL 500 MG CAPSULE	T3	PA SP HD
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO	T3	PA SP HD
<b>NEONATAL FC RECEPTOR (FCRN) INHIBITORS</b>		
VYVGART HYTRULO	T3	PA SP HD
<b>OINTMENT/CREAM BASES</b>		
RADIAGEL	T1	
<b>PHARMACOLOGICAL CHAPERONE-ALPHA-GALACTOSID.A STABZ</b>		
GALAFOLD	T3	PA SP HD
<b>PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE</b>		
<i>javygtor 100 mg powder packet (Kuvan)</i>	T1	PA SP
<i>javygtor 100 mg tablet (Kuvan)</i>	T1	PA SP HD
<i>javygtor 500 mg powder packet (Kuvan)</i>	T1	PA SP
<i>sapropterin dihydrochloride (Kuvan)</i>	T1	PA SP
<i>sapropterin dihydrochloride (Kuvan)</i>	T1	PA SP HD
<b>PROTEIN STABILIZERS</b>		
ATTRUBY	T3	PA QL(4 TABS/DAY) SP
VYNDAMAX	T3	PA QL(1 CAP/DAY) SP HD
VYNDAQEL	T3	PA QL(4 CAPS/DAY) SP
<b>RETINOIC ACID RECEPTOR (RAR) AGONISTS</b>		
SOHONOS	T3	PA SP
<b>SOLVENTS</b>		
<i>cvs isopropyl alcohol 91%</i>	T1	
CVS ISOPROPYL ALCOHOL 91%	T1	
<i>cvs isopropyl rub alcohol 70%</i>	T1	
CVS ISOPROPYL RUB ALCOHOL 70%	T3	
<i>eql isopropyl alcohol 91%</i>	T1	
<i>eql isopropyl rub alcohol 70%</i>	T1	
FT ISOPROPYL ALCOHOL 91%	T1	

T1 – Typically Generics

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PPACA – No Cost-Share Preventive Medication

T2 – Typically Preferred Brands

QL – Quantity Limit

SP – Specialty Medication

CSL – Oral cancer medication subject to cost-share limits

T3 – Typically Non-Preferred Brands

ST – Step Therapy

HD – May require home delivery pharmacy

## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Miscellaneous) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>SOLVENTS (cont.)</b>		
FT ISOPROPYL RUB ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 70%	T3	
GNP ISOPROPYL ALCOHOL 91%	T1	
<i>gnp isopropyl alcohol 99%</i>	T1	
GS ISOPROPYL ALCOHOL 70%	T3	
GS ISOPROPYL ALCOHOL 91%	T1	
<i>hm isopropyl alcohol 70%</i>	T1	
<i>hm isopropyl alcohol 91%</i>	T1	
INSTACLEAN	T1	
ISOPROPANOL	T1	
<i>isopropyl 70% alcohol</i>	T1	
<i>isopropyl alcohol</i>	T1	
<i>isopropyl alcohol 70%</i>	T1	
ISOPROPYL ALCOHOL 70%	T3	
<i>isopropyl alcohol 91%</i>	T1	
<i>isopropyl alcohol 99%</i>	T1	
<i>isopropyl rubbing alcohol 70%</i>	T1	
ISOPROPYL RUBBING ALCOHOL 70%	T3	
ISOPROPYL RUBBING ALCOHOL 91%	T1	
<i>kro isopropyl alcohol 91%</i>	T1	
MURI-LUBE MINERAL OIL	T1	
<i>polyethylene glycol</i>	T1	
<i>ra isopropyl alcohol 70%</i>	T1	
<i>ra isopropyl alcohol 91%</i>	T1	
<i>sm isopropyl alcohol 70%</i>	T1	
<i>swan isopropyl alcohol 70%</i>	T1	
<b>METABOLIC DEFICIENCY AGENTS</b>		
VYKAT XR	T3	PA SP

### UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary)

<b>METABOLIC DEFICIENCY AGENTS</b>		
<i>betaine (Cystadane)</i>	T1	SP
CULTURELLE IBS COMPLETE SUPPRT	T3	
CYSTADANE ( <i>betaine</i> )	T3	SP

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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>METABOLIC DEFICIENCY AGENTS (cont.)</b>		
<i>levocarnitine</i> (Carnitor Sf)	T1	
<i>levocarnitine</i> (Carnitor)	T1	
<i>levocarnitine (with sugar)</i> (Carnitor)	T1	

## UNCLASSIFIED DRUG PRODUCTS (Osteoporosis Products)

### BONE FORMATION STIM. AGENTS- PARATHYROID HORMONE

<i>teriparatide</i> (Bonsity)	T1	PA QL(0.09 MLS/DAY) SP HD
<i>teriparatide</i> (Forteo)	T1	PA QL(0.09 MLS/DAY) SP HD

### BONE RESORPTION INHIBITOR AND VITAMIN D COMBS.

FOSAMAX PLUS D	T2	ST HD
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### BONE RESORPTION INHIBITORS

<i>alendronate sodium</i>	T1	HD
<i>alendronate sodium</i> (Fosamax)	T1	HD
ATELVIA ( <i>risedronate sodium dr</i> )	T3	ST HD
BINOSTO	T3	ST HD
FOSAMAX ( <i>alendronate sodium</i> )	T3	ST HD
<i>ibandronate sodium</i>	T1	HD
<i>raloxifene hcl</i> (Evista)	T1	HD PPACA
<i>risedronate sodium</i>	T1	HD
<i>risedronate sodium</i> (Actonel)	T1	HD
<i>risedronate sodium</i> (Atelvia)	T1	HD

## UNCLASSIFIED DRUG PRODUCTS (Pain Relief And Inflammatory Disease)

### ANTI-INFLAM. INTERLEUKIN-I RECEPTOR ANTAGONIST

ARCALYST	T3	PA SP
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### ANTI-INFLAMMATORY, INTERLEUKIN-I BETA BLOCKERS

ILARIS	T3	PA SP HD
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### FIBROMYALGIA AGENTS, SEROTONIN-NOREPINEPH RU INHIB

SAVELLA	T3	
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### IMMUNOMODULATOR, B-LYMPHOCYTE STIM (BLYS)-SPEC INHIB

BENLYSTA	T3	PA SP HD
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## UNCLASSIFIED DRUG PRODUCTS (Skin Conditions)

### INTERLEUKIN-I3 (IL-I3) INHIBITORS, MAB

ADBRY	T2	PA SP HD
ADBRY AUTOINJECTOR	T2	PA SP HD

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# List of Prescription Medications

## UNCLASSIFIED DRUG PRODUCTS (Skin Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>INTERLEUKIN-13 (IL-13) INHIBITORS, MAB (cont.)</b>		
EBGLYSS PEN	T2	PA SP
EBGLYSS SYRINGE	T2	PA SP
<b>JANUS KINASE (JAK) INHIBITORS</b>		
LEQSELVI	T3	PA QL(2 TABS/DAY) SP HD
LITFULO	T3	PA QL(1 CAP/DAY) SP HD
<b>WOUND HEALING AGENTS, LOCAL</b>		
FILSUVEZ	T3	PA SP

## UNCLASSIFIED DRUG PRODUCTS (Substance Abuse)

<b>OPIOID WITHDRAWAL THER, ALPHA-2 ADRENERGIC AGONIST</b>		
<i>lofexidine hcl</i> (Lucemyra)	T1	QL(192 TABS/30 DAYS)
LUCEMYRA ( <i>lofexidine hcl</i> )	T2	QL(192 TABS/30 DAYS)
<b>OPIOID WITHDRAWAL THERAPY AGENTS, OPIOID-TYPE</b>		
<i>buprenorphine hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i>	T1	
<i>buprenorphine hcl/naloxone hcl</i> (Suboxone)	T1	
SUBOXONE ( <i>buprenorphine-naloxone</i> )	T3	
ZUBSOLV	T2	

## UNCLASSIFIED DRUG PRODUCTS (Transplant Medications)

<b>RHO KINASE INHIBITOR</b>		
REZUROCK	T3	PA SP

## UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions)

<b>BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS</b>		
<i>alfuzosin hcl</i> (Uroxatral)	T1	HD
<i>dutasteride</i> (Avodart)	T1	HD
<i>finasteride</i> (Proscar)	T1	HD
<i>silodosin 4 mg capsule</i> (Rapaflo)	T1	QL(1 CAP/DAY) HD
<i>silodosin 8 mg capsule</i> (Rapaflo)	T1	HD
<i>tamsulosin hcl</i>	T1	HD
<b>BPH 5-ALPHA-REDUCTASE INHIB-ALPHA1-ADRENOCEP ANTAG</b>		
<i>dutasteride/tamsulosin hcl</i> (Jalyn)	T1	HD
<b>CYSTINE-DEPLETING AGENTS, NEPHROPATHIC CYSTINOSIS</b>		
CYSTAGON	T2	SP

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Urinary Tract Conditions) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ENDOTHELIN RECEPTOR ANTAGONISTS</b>		
VANRAFIA	T2	PA QL(1 TAB/DAY) SP
<b>KIDNEY STONE AGENTS</b>		
<i>tiopronin</i> (Thiola Ec)	T1	SP
<i>tiopronin 100 mg tablet</i> (Thiola)	T1	SP
<i>tiopronin dr 100 mg tablet</i> (Thiola Ec)	T1	SP HD
<i>tiopronin dr 300 mg tablet</i> (Thiola Ec)	T1	SP HD
<b>OVERACTIVE BLADDER AGENTS, BETA-3 ADRENERGIC RECEPTOR ANTAGONISTS</b>		
<i>mirabegron er 25 mg tablet</i> (Myrbetriq)	T1	QL(1 TAB/DAY) HD
<i>mirabegron er 50 mg tablet</i> (Myrbetriq)	T1	HD
<b>URINARY TRACT ANTI-SPASMODIC, M(3) SELECTIVE ANTAGONISTS</b>		
<i>darifenacin er 15 mg tablet</i>	T1	HD
<i>darifenacin er 7.5 mg tablet</i>	T1	QL(1 TAB/DAY) HD
<i>solifenacin 10 mg tablet</i> (Vesicare)	T1	HD
<i>solifenacin 5 mg tablet</i> (Vesicare)	T1	QL(1 TAB/DAY) HD
<b>URINARY TRACT ANTI-SPASMODIC/ANTI-INCONTINENCE AGENTS</b>		
<i>fesoterodine er 4 mg tablet</i> (Toviaz)	T1	QL(1 TAB/DAY) HD
<i>fesoterodine er 8 mg tablet</i> (Toviaz)	T1	HD
<i>flavoxate hcl</i>	T1	HD
<i>oxybutynin 5 mg tablet</i>	T1	HD
<i>oxybutynin 5 mg/5 ml soln cup</i>	T1	HD
<i>oxybutynin 5 mg/5 ml solution</i>	T1	HD
<i>oxybutynin 5 mg/5 ml syrup</i>	T1	HD
<i>oxybutynin chloride</i>	T1	HD
<i>tolterodine tart er 2 mg cap</i> (Detrol La)	T1	QL(1 CAP/DAY) HD
<i>tolterodine tart er 4 mg cap</i> (Detrol La)	T1	HD
<i>tolterodine tartrate</i> (Detrol)	T1	HD
<i>tropium chloride</i>	T1	HD
<b>UNCLASSIFIED DRUG PRODUCTS (Weight Management)</b>		
<b>APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYNDROME</b>		
<i>megestrol 400 mg/10 ml cup</i>	T1	
<i>megestrol 625 mg/5 ml susp</i>	T1	

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## List of Prescription Medications

### UNCLASSIFIED DRUG PRODUCTS (Weight Management) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>APPETITE STIM. FOR ANOREXIA, CACHEXIA, WASTING SYND. (cont.)</b>		
<i>megestrol acet 40 mg/ml susp</i>	T1	
<i>megestrol acet 400 mg/10 ml</i>	T1	

### VITAMINS (Nutritional/Dietary)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>ANTIOXIDANT MULTIVITAMIN COMBINATIONS</b>		
MACUVEX	T2	
MACUZIN	T2	
<b>FOLIC ACID PREPARATIONS</b>		
ENLYTE	T2	
<i>folic acid</i>	T1	
<i>folic acid/b6/ca phos/ginger</i>	T1	
<b>GERIATRIC VITAMIN PREPARATIONS</b>		
REQ49+	T2	
<b>MULTIVITAMIN PREPARATIONS</b>		
ANIMI-3	T2	
BACMIN	T2	
CONCEPT DHA ( <i>mvn-min75/iron/iron ps/om3/dha</i> )	T3	
CONCEPT OB ( <i>mvn-min 74/iron fum/iron/fa</i> )	T2	
CORVITE	T2	
DIALYVITE 800 WITH IRON	T2	
ENBRACE HR	T2	
<i>folic/mvi ther-min/lycop/lut</i>	T1	
FORTAVIT	T2	
<i>multivit 47/iron/folate 1/dha</i>	T1	
<i>multivit no.18/iron no.1/folic</i> (Tandem Plus)	T1	
<i>multivit no.51/iron/folic acid</i>	T1	
<i>multivit-min69/iron/folic acid</i>	T1	
<i>multivit-mins no.7/folic acid</i>	T1	
<i>mv-mins 71/iron/folic no.1/dha</i>	T1	
<i>mvn no.53/iron/folic/dss/dha</i>	T1	
<i>mvn-min 74/iron fum/iron/fa</i> (Concept Ob)	T1	
<i>mvn-min75/iron/iron ps/om3/dha</i> (Concept Dha)	T1	

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# List of Prescription Medications

## VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>MULTIVITAMIN PREPARATIONS (cont.)</b>		
NEEVODHA	T2	
NESTABS ONE	T2	
NIVA-PLUS ( <i>multivit-min 60/iron fum/folic</i> )	T1	
OB COMPLETE	T3	
<i>om-3/dha/epa/b12/fa/b6/phytost</i>	T1	
PRENATE AM	T2	
PRENATE CHEWABLE	T2	
PRENATE ESSENTIAL	T2	
PROTECT IRON	T2	
STROVITE FORTE ( <i>multivit,iron,min 5/folic acid</i> )	T2	
STROVITE ONE	T2	
TANDEM PLUS ( <i>multivit no.18/iron no.1/folic</i> )	T3	
UDAMIN SP	T2	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
FLORIVA 0.25 MG CHEW TABLET	T2	PPACA
FLORIVA 0.5 MG CHEWABLE TABLET	T2	PPACA
FLORIVA 1 MG CHEWABLE TABLET	T2	PPACA
<i>ped mvit a,c,d3 no.21/fluoride</i>	T1	PPACA
<i>pedi multivit no.12 w-fluoride</i>	T2	PPACA
POLY-VI-FLOR	T2	PPACA
QUFLORA FE	T2	
QUFLORA PED 0.25 MG CHEW TAB	T2	
QUFLORA PED 0.25 MG/ML DROP	T2	PPACA
QUFLORA PED 0.5 MG CHEW TAB	T2	
QUFLORA PED 0.5 MG/ML DROP	T2	PPACA
QUFLORA PED 1 MG CHEW TAB	T2	PPACA
TRI-VI-FLOR	T2	PPACA
<b>VITAMIN B12 PREPARATIONS</b>		
<i>cyanocobalamin (vitamin b-12)</i>	T1	
<i>cyanocobalamin (vitamin b-12) (Nascobal)</i>	T1	
<b>VITAMIN B PREPARATIONS</b>		
b comp no3/folic/c/biotin/zinc	T1	HD
b complex 11/folic/c/biot/zinc	T1	HD

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## List of Prescription Medications

### VITAMINS (Nutritional/Dietary) (cont.)

Prescription Drug Name	Drug Tier	Coverage Requirements and Limits
<b>VITAMIN B PREPARATIONS (cont.)</b>		
<i>cyanocobalamin/folic ac/vit b6</i>	T1	HD
<i>cyanocobalamin/folic ac/vit b6 (Niva-Fol)</i>	T1	HD
DIALYVITE 3000	T2	HD
DIALYVITE 5000	T2	HD
DIALYVITE SUPREME D	T2	HD
<i>folic acid/vit b complex and c</i>	T1	HD
<i>folic acid/vit bcomp,c/cu/zinc</i>	T1	HD
METHAVER	T2	HD
NEPHRON FA	T3	HD
NIVA-FOL (cyanocobalamin/folic ac/vit b6)	T1	HD
VITAL-D RX	T2	HD
VITA-RESPA	T2	HD
<b>VITAMIN D PREPARATIONS</b>		
<i>calcitriol 0.25 mcg capsule</i>	T1	
<i>calcitriol 0.5 mcg capsule</i>	T1	
<i>calcitriol 1 mcg/ml solution (Rocaltrol)</i>	T1	
<i>ergocalciferol (vitamin d2)</i>	T1	HD
<b>VITAMIN K PREPARATIONS</b>		
MEPHYTON ( <i>phytonadione (vit k1)</i> )	T3	
<i>phytonadione (vit k1) (Mephyton)</i>	T1	
<b>VITAMINS (Vitamins)</b>		
<b>MULTIVITAMIN PREPARATIONS</b>		
CITRANATAL MEDLEY	T3	
<b>PEDIATRIC VITAMIN PREPARATIONS</b>		
POLY-VI-FLOR	T2	PPACA
POLY-VI-FLOR WITH IRON	T2	PPACA

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## Exclusions and limitations for coverage

Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. If your plan provides coverage for certain preventive prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, the prescription may not be covered. Certain drugs may require prior authorization, or be subject to step therapy, quantity limits or other utilization management requirements.

Plans generally do not provide coverage for the following under the pharmacy benefit, except as required by state or federal law, or by the terms of your specific plan:<sup>11</sup>

- Over-the-counter (OTC) medicines (those that do not require a prescription) except insulin unless state or federal law requires coverage of such medicines.
  - Prescription medications or supplies for which there is a prescription or OTC therapeutic equivalent or therapeutic alternative.
  - Doctor-administered injectable medications covered under the Plan's medical benefit, unless otherwise covered under the Plan's prescription drug list or approved by Cigna Healthcare.
  - Implantable contraceptive devices covered under the Plan's medical benefit.
  - Medications that are not medically necessary.
  - Experimental or investigational medications, including U.S. Food and Drug Administration (FDA)-approved medications used for purposes other than those approved by the FDA unless the medication is recognized for the treatment of the particular indication.
  - Medications that are not approved by the FDA.
  - Prescription and non-prescription devices, supplies, and appliances other than those supplies specifically listed as covered.
  - Medications used for fertility,<sup>12</sup> sexual dysfunction, cosmetic purposes, weight loss, smoking cessation,<sup>12</sup> or athletic enhancement.
  - Prescription vitamins (other than prenatal vitamins) or dietary supplements unless state or federal law requires coverage of such products.
  - Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
  - Replacement of prescription medications and related supplies due to loss or theft.
  - Medications which are to be taken by or administered to a covered person while they are a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
  - Prescriptions more than one year from the date of issue.
  - Coverage for prescription medication products for the amount dispensed (days' supply) which is more than the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which is more than the quantity limit(s) or dosage limit(s) set by the P&T Committee.
  - More than one prescription order or refill for a given prescription supply period for the same prescription medication product prescribed by one or more doctors and dispensed by one or more pharmacies.
  - Prescription medication products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- In addition to the plan's standard pharmacy exclusions, certain new FDA-approved medication products (including, but not limited to, medications, medical supplies or devices that are covered under standard pharmacy benefit plans) may not be covered for the first six months of market availability unless approved by Cigna Healthcare as medically necessary.

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Health benefit plans vary, but in general to be eligible for coverage a drug must be approved by the U.S. Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Certain features described in this document may not be applicable to your specific health plan, and plan features may vary by location and plan type. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.



1. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
2. Smoking cessation medications are not usually covered under the plan, except as required by law or by the terms of your specific plan. Costs and complete details of the plan's prescription drug coverage, including a full list of exclusions and limitations, are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
3. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.
4. U.S. Food and Drug Administration (FDA) website, "Generic Drug Facts." Content current as of 11/01/21. [fda.gov/drugs/generic-drugs/generic-drug-facts](https://www.fda.gov/drugs/generic-drugs/generic-drug-facts).
5. U.S. Food and Drug Administration (FDA) website, "Biosimilar Basics for Patients." Last updated 08/01/24. [fda.gov/drugs/biosimilars/biosimilars-basics-patients](https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients).
6. **Not all plans offer Express Scripts Pharmacy and Accredo as covered pharmacy options.** Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare, Evernorth Health Services, Express Scripts and Accredo are all part of The Cigna Group. This means we have an ownership interest in Express Scripts Pharmacy's home delivery services and Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network (as your plan allows).
7. Your plan pays the cost for standard shipping.
8. Express Scripts Pharmacy can automatically refill certain medications. Log in to the myCigna App or myCigna.com, or call 800.835.3784, to sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for the Express Scripts texting service. You can do this online or when you call 800.835.3784 to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
9. You can only refill certain specialty medications by text. To get text messages, you'll have to sign up for Accredo's texting service. You can do this when you call Accredo to refill your prescription. Once you sign up, just reply to their welcome text to get started. Standard text messaging rates apply.
10. **For insured plans that must follow Delaware's state insurance laws:** Brand-name antidepressants, smoking cessation, attention deficit hyperactivity disorder (ADHD) and anti-psychotic medications that don't have a generic equivalent available will be covered as Tier 2 (preferred brand). This is true even if the medication is listed as Tier 3 (non-preferred brand) on your plan's drug list. To find out how your specific plans covers these medications, log in to the myCigna App or myCigna.com, or call the number on your ID card.
11. Costs and complete details of the plan's prescription drug coverage are set forth in the plan documents. If there are any differences between the information provided here and the plan documents, the information in the plan documents takes complete precedence.
12. **For plans that must follow state insurance laws, such as Delaware:** Your plan may provide coverage for infertility medications and smoking cessation medications even if this drug list states that your plan may not cover them. To find out if your specific plan covers these medications, log in to the myCigna App or myCigna.com, or check your plan materials.

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SW Room 509F, HHH Building  
Washington, DC 20201  
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**Chinese – 注意:** 如果您讲中文, 我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供, 以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

**Vietnamese – XIN LƯU Ý:** Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean – 주의:** 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

**Tagalog – PAUNAWA:** Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian – ВНИМАНИЕ:** Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic - تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711).

**French Creole – ATANSYON:** Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French – ATTENTION :** Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese – ATENÇÃO:** Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish – UWAGA:** Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese – 注意:** 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

**Italian – ATTENZIONE:** Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

**German – Achtung:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) - همچنین، وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنند، توجه: اگر به فارسی تماش بگیرید یا با (شماره 711 را بگیرید: TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید.**